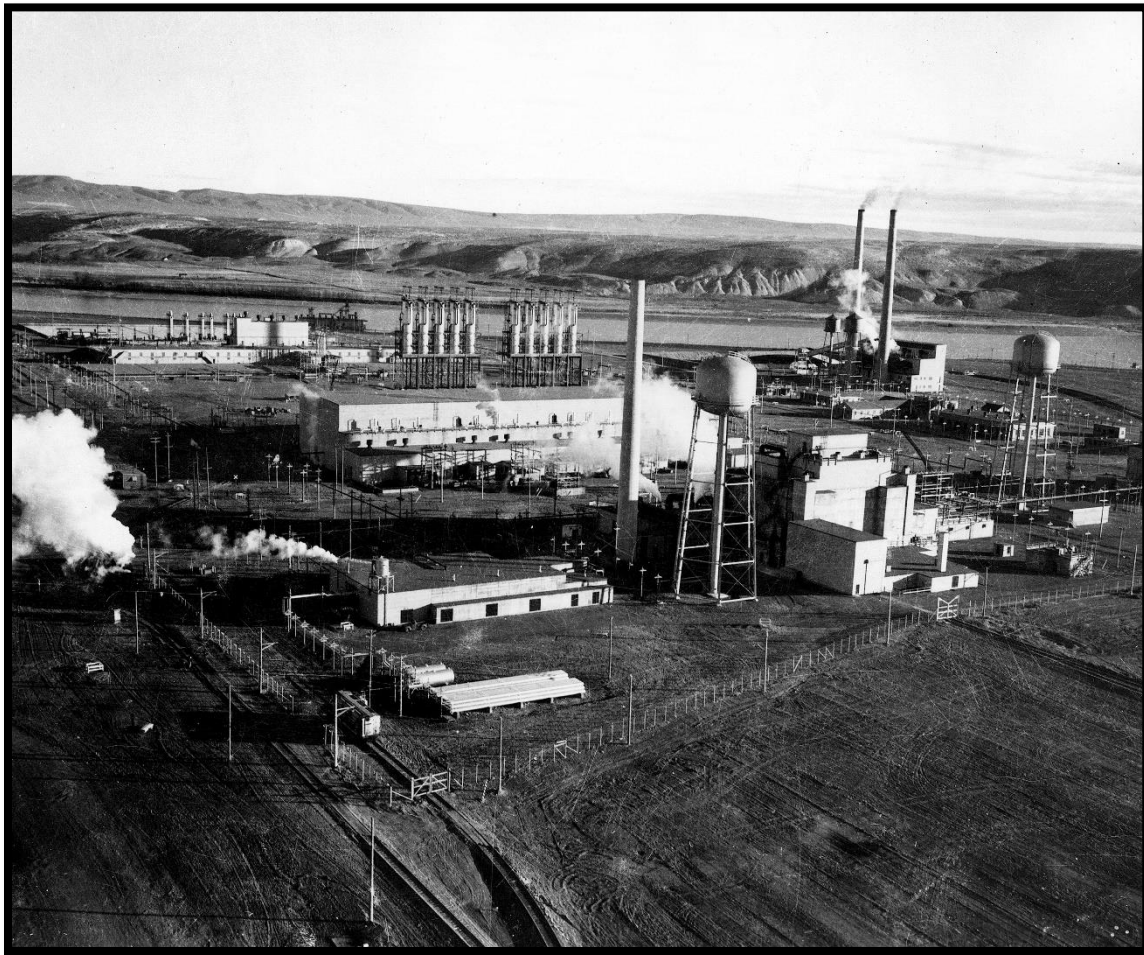


OFFICE OF THE OMBUDSMAN

FOR THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM

2020 ANNUAL REPORT TO CONGRESS



OFFICE OF THE OMBUDSMAN

UNITED STATES DEPARTMENT OF LABOR

Cover photo: The Oak Ridge Gaseous Diffusion Plant.

Cover photo credit: courtesy of the U.S. Department of Energy via Flickr.

U.S. Department of Labor

Office of the Assistant Secretary
for Administration and Management
Washington, D.C. 20210



July 2, 2021

The Honorable Kamala D. Harris
President of the United States Senate
Washington, DC 20510

Dear Madam President:

I am pleased to present the 2020 Annual Report of the Ombudsman for the Energy Employees
Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

A handwritten signature in blue ink, appearing to read "Amanda M. Fallon", is positioned above the printed name.

Amanda M. Fallon
Acting Ombudsman for the Energy Employees
Occupational Illness Compensation Program

Enclosure

U.S. Department of Labor

Office of the Assistant Secretary
for Administration and Management
Washington, D.C. 20210



July 2, 2021

The Honorable Nancy Pelosi
Speaker of the U.S. House of Representatives
Washington, DC 20515

Dear Speaker Pelosi:

I am pleased to present the 2020 Annual Report of the Ombudsman for the Energy Employees
Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

A handwritten signature in blue ink, appearing to read "Amanda M. Fallon".

Amanda M. Fallon
Acting Ombudsman for the Energy Employees
Occupational Illness Compensation Program

Enclosure

Table of Contents

PREFACE TO THE REPORT	1
INTRODUCTION.....	3
SUMMARY OF ISSUES AND RECOMMENDATIONS	7
TABLES.....	14
TABLE 1 – COMPLAINTS, GRIEVANCES, AND REQUESTS FOR ASSISTANCE BY NATURE OF COMPLAINT.....	15
TABLE 2 - COMPLAINTS BY FACILITY	17
Chapter 1 – Effectiveness of Outreach Efforts.....	19
Chapter 2 – Medical Bill Issues	22
A. Complaints Related to the Medical Billing Contractor Transition.....	22
B. Difficulties Obtaining Assistance with Medical Billing.....	24
C. Inadequate Assistance with Medical Bill Coding Issues.....	27
Chapter 3 – Medical Treatment Issues	31
A. Issues Related to COVID-19	31
B. Difficulties and Delays in Obtaining Medical Care and Prescription Medication	33
C. Difficulties with Expedited Adjudication and Medical Care	37
Chapter 4 – Difficulties Understanding the EEOICPA Claims Process.....	40
Chapter 5 – Issues Related to Impairment Claims	45
Chapter 6 – Customer Service, Delays, and Other Administrative Issues	50
A. Communication Issues.....	50
B. Delays	54
C. Insensitive/Rude Behavior by DEEOIC Staff	58

Chapter 7 – Other Complaints in 2020	61
A. Industrial Hygienist and Contract Medical Consultant Issues.....	61
B. Other Complaints.....	63
 APPENDIX 1 - ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT	64

PREFACE TO THE REPORT

In this Annual Report to Congress, the Ombudsman for the Energy Employees Occupational Illness Compensation Program sets forth the complaints, grievances, and requests for assistance received during calendar year 2020, and provides an assessment of the most common difficulties encountered by claimants and potential claimants in that year. However, before addressing the complaints, grievances and requests for assistance received in 2020, we would like to acknowledge some of the efforts undertaken by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) in calendar year 2020 to assist claimants in filing and processing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA):

- In March 2020, in response to the coronavirus pandemic, DEEOIC cancelled in-person outreach events and quickly transitioned to online monthly webinars. The webinars covered many of the same topics presented in the authorized representative (AR) workshops as well as a question and answer session. DEEOIC has posted the slides from each webinar on the DEEOIC website.
- OWCP launched a new and enhanced website for all its programs, including DEEOIC.
- DEEOIC published several updated versions of the Procedure Manual. The changes to the Procedure Manual included:
 - New duties and responsibilities for the Resource Center (RC) staff;
 - Updates to medical bill processing;
 - The removal of Exhibit 18-1 (Matrix for Confirming Sufficient Evidence of Non-Cancerous Covered Illnesses);
 - Additional guidance for calculating workday requirements in instances where evidence supports an onsite presence at a designated Special Exposure Cohort (SEC) facility for 24 hours;
 - Changes to presumptive standards applied for evaluating claims for angiosarcoma, asbestosis, bladder cancer, COPD, kidney cancer, laryngeal cancer, leukemia, lung cancer, non-Hodgkin's lymphoma, ovarian cancer, and pleural plaques. The changes were incorporated into the Procedure Manual Exhibit 15-4, Exposure and Causation Presumptions with Development Guidance for Certain Conditions; and,
 - Added a new exception to coordination of State Workers' Compensation (SWC) benefits.

- The following outreach events, workshops, and webinars were held:
 - DEEOIC Energy Outreach Event in Kansas City, Missouri, on January 9, 2020;
 - Authorized Representative Workshop in Santa Fe, New Mexico on February 25-26, 2020;
 - Joint Outreach Task Group (JOTG) Meeting in Santa Fe, New Mexico on February 27, 2020;
 - Webinar: Updates for Stakeholders on June 25, 2020;
 - Webinar: Causation and Dose Reconstruction on July 29, 2020;
 - Webinar: Site Exposure Matrices (SEM) and Former Worker Program on August 26, 2020;
 - Webinar: Impairment and Wage-Loss on September 15, 2020;
 - Webinar: Role of the Resource Center and Authorized Representative Services on October 14, 2020;
 - Webinar: DEEOIC Website Tour and DOE Records Search on November 12, 2020; and,
 - Webinar: Radiation Exposure Compensation Act – U.S. Department of Justice and DEEOIC on December 9, 2020.

In addition, we wish to acknowledge the many instances throughout the year where members of the DEEOIC staff assisted claimants and/or our Office in resolving matters brought to their attention.

INTRODUCTION

Section 7385s-15 of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, requires the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program (the Office) to submit an annual report to Congress. *See* 42 U.S.C. § 7385s-15. In this annual report, we are to set forth: (a) the numbers and types of complaints, grievances, and requests for assistance received by the Office during the preceding year; and (b) an assessment of the most common difficulties encountered by claimants and potential claimants during that year. *See* 42 U.S.C. § 7385s-15(e). The following is the Office's annual report for calendar year 2020.

I. An Overview of the Energy Employees Occupational Illness Compensation Program Act (the EEOICPA)

Congress enacted the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, on October 30, 2000. The purpose of the EEOICPA is to provide for timely, uniform, and adequate compensation of covered employees, and where applicable, survivors of such employees, suffering from illnesses incurred by such employees in the performance of duty for the Department of Energy (DOE) and certain of its contractors and subcontractors. 42 U.S.C. § 7384d(b).

In enacting this program, Congress recognized that:

1. Since World War II, Federal nuclear activities have been explicitly recognized under Federal law as activities that are ultra-hazardous. Nuclear weapon production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposures to radioactive substances and beryllium that, even in small amounts, can cause medical harm.
2. Since the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the Department of Energy and at sites of vendors who supplied the Cold War effort were put at risk without their knowledge and consent for reasons that, documents reveal, were driven by fears of adverse publicity, liability, and employee demands for hazardous duty pay.
3. Many previously secret records have documented unmonitored exposures to radiation and beryllium and continuing problems at these sites across the Nation, at which the Department of Energy and its predecessor agencies have been, since World War II, self-regulating with respect to nuclear safety and occupational safety and health. No other hazardous Federal activity has been permitted to be carried out under such sweeping powers of self-regulation.

See 42 U.S.C. § 7384(a)(1),(2), and (3).

As originally enacted in October 2000, the EEOICPA contained two parts, Part B and Part D. Part B, which is administered by the Department of Labor (DOL), provides the following compensation and benefits:

- Lump-sum payment of \$150,000 and the payment of medical expenses (for the accepted illness starting as of the date of filing) for:
 - a) Employees of the DOE, as well as its contractors, subcontractors, and employees of atomic weapons employers (AWEs) with radiation-induced cancer if: (a) the employee developed cancer after working at a covered facility; and (b) the cancer is “at least as likely as not” related to covered employment.¹
 - b) Employees who are members of Special Exposure Cohort (SEC) and who develop one of the specified cancers outlined in 42 U.S.C. § 7484l(17).²
 - c) All federal employees, as well as employees of the DOE, its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and who develop Chronic Beryllium Disease (CBD).
 - d) Employees of the DOE or its contractors and subcontractors who worked at least 250 days during the mining of tunnels at underground nuclear weapons test sites in Nevada or Alaska and who develop chronic silicosis.If the employee is no longer living, eligible survivors of the employees listed above are entitled to \$150,000 in lump sum compensation under Part B.
- Uranium miners, millers, and ore transporters, or their survivors, who are awarded \$100,000 under Section 5 of the Radiation Exposure Compensation Act (RECA), 42 U.S.C. § 2210 note, are entitled under the EEOICPA to a lump-sum payment of \$50,000 and to medical expenses for the accepted illness.
- All federal employees, as well as employees of the DOE, as well as its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and whose claims for beryllium sensitivity are accepted under Part B are entitled to medical monitoring to check for the development of CBD.

Part D of the EEOICPA required the DOE to establish a system by which DOE contractor employees and their eligible survivors could seek assistance in obtaining state workers’ compensation benefits if a Physicians Panel determined that the employee sustained an accepted illness as a result of work-related exposure to a toxic substance at a DOE facility. On October 28, 2004, Congress abolished Part D and created Part E as Subtitle E of Title XXXI of the Ronald

¹ An atomic weapons employer is an entity, other than the United States, that: (A) processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; and (B) is designated by the Secretary of Energy as an atomic weapons employer for purposes of the compensation program [EEOICPA]. See 42 U.S.C. § 7384l(4).

² If a claimant qualifies for inclusion in a SEC class and develops one of the specified cancers, that claimant receives compensation for that specified cancer without the completion of a radiation dose reconstruction by the National Institute for Occupational Safety and Health, and without a determination by DOL of the probability of causation that the cancer was caused by exposure to radiation at a covered facility.

W. Reagan National Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 118 Stat. 1811, 2178 (October 28, 2004). Part E is administered by DOL.

The compensation and benefits allowable under Part E are as follows:

- DOE contractor and subcontractor employees who develop an illness due to exposure to toxic substances at certain DOE facilities are entitled to medical expenses and may receive monetary compensation of up to \$250,000 for impairment and/or wage-loss.
- Eligible survivors of DOE contractor and subcontractor employees receive compensation of \$125,000 if the employee's death was caused, contributed to, or aggravated by the covered illness. If the employee had between 10 and 19 years of wage-loss, the survivor receives an additional \$25,000. If the worker had 20 or more years of wage-loss, the survivor receives an additional \$50,000.
- Uranium miners, millers, and ore transporters are eligible for medical benefits, as well as up to \$250,000 in monetary compensation for impairment and/or wage-loss, if they develop an illness as a result of toxic exposure at a facility covered under Section 5 of RECA. (These uranium miners, millers, or ore transporters are eligible for compensation and medical benefits under Part E even if they did not receive compensation under RECA).

DOL has primary authority for administering Part B and Part E of the EEOICPA. However, other federal agencies are also involved with the administration of this program.

- The DOE ensures that all available worker and facility records and data are provided to DOL. This includes: (1) providing DOL and/or the National Institute for Occupational Safety and Health (NIOSH) with information related to individual claims such as employment verification and exposure records; (2) supporting DOL, NIOSH, and the Advisory Board on Radiation and Worker Health with large-scale records research and retrieval efforts at various DOE sites; (3) conducting research, in coordination with DOL and NIOSH on issues related to covered facility designations; and (4) hosting the Secure Electronic Records Transfer (SERT) system, a DOE hosted environment where DOL, NIOSH, and DOE can securely share records and data.
- NIOSH conducts activities to assist claimants and supports the role of the Secretary of Health and Human Services (HHS) under EEOICPA. These activities include: (1) developing scientific guidelines for determining whether a cancer is related to the worker's occupational exposure to radiation; (2) developing methods to estimate worker exposure to radiation (dose reconstruction); (3) using the dose reconstruction regulations to develop estimates of which classes of workers can be considered for inclusion in a SEC class; and (4) providing staff support for the independent Advisory Board on Radiation and Worker Health that advises HHS and NIOSH on dose reconstructions and SEC petitions.

- The Ombudsman to NIOSH helps individuals with a variety of issues related to the SEC petition process and the dose reconstruction process. The Ombudsman to NIOSH also conducts outreach to promote a better understanding of the EEOICPA, as well as the claims process.

II. The Office of the Ombudsman

Public Law 108-375, which was enacted on October 28, 2004, also established within the DOL an Office of the Ombudsman. The National Defense Authorization Act for 2021, which became effective January 1, 2021, amended the EEOICPA to provide for the permanent extension of the Office of the Ombudsman within DOL. Public Law 116-283, § 3145 (Jan. 1, 2021). The EEOICPA outlines four (4) specific duties for the Office:

1. Provide information to claimants and potential claimants on the benefits available under Part B and Part E, and on the requirements and procedures applicable to the provision of such benefits.
2. Provide guidance and assistance to claimants.
3. Make recommendations to the Secretary of Labor regarding the location of resource centers for the acceptance and development of EEOICPA claims.
4. Carry out such other duties as the Secretary specifies.

See 42 U.S.C. § 7385s-15(c).

The EEOICPA also requires the Office to submit an annual report to Congress which sets forth:

1. The number and types of complaints, grievances, and requests for assistance received by the Office during the preceding year; and
2. An assessment of the most common difficulties encountered by claimants and potential claimants during the preceding year.

See 42 U.S.C. § 7385s-15(e)(2).

Additionally, not later than 180 days after the submission to Congress of the annual report, the Secretary shall submit to Congress in writing, and post on the public Internet website of the Department of Labor, a response to the report that—

- (A) includes a statement of whether the Secretary agrees or disagrees with the specific issues raised by the Ombudsman in the report;
- (B) if the Secretary agrees with the Ombudsman on those issues, describes the actions to be taken to correct those issues; and
- (C) if the Secretary does not agree with the Ombudsman on those issues, describes the reasons the Secretary does not agree.

See 42 U.S.C. § 7385s-15(e)(4).

SUMMARY OF ISSUES AND RECOMMENDATIONS

1. Effectiveness of Outreach Efforts: Outreach serves two purposes: (1) it is a way to disseminate information to those who are not aware of the EEOIC program; and (2) it offers an opportunity for claimants to ask questions and obtain additional information about the program. DEEOIC should continue to expand its outreach. In developing strategies for outreach, it is critical for DEEOIC to continue to develop strategies that effectively disseminate information to those who do not have access to, or only limited access to, the internet.

In light of the pandemic, DEEOIC is to be commended for its efforts to continue to disseminate information by holding monthly webinars. We talked to claimants who told us they found these webinars to be very helpful. Yet, we also encountered claimants with limited or no access to the internet who were not aware of, or could not access these webinars. To ensure that information is disseminated as broadly as possible, if face-to-face outreach events are limited, then DEEOIC should develop other means to effectively disseminate information to those who do not have, or have limited access to the internet.

There are also many former employees and surviving family members of employees of AWE facilities, beryllium vendors, uranium mines, uranium mills, and uranium ore transporters. Many of the companies that operated these facilities have changed ownership over time. As a result, former workers or their surviving family members may not be aware that work done for a predecessor of the current company may qualify as covered employment under the EEOICPA. Moreover, because the DOE employee rosters do not include individuals who worked at these types of facilities, targeted outreach by DEEOIC is likely the only way these individuals or their surviving family members will learn of the program.

Furthermore, with the Radiation Exposure Compensation Act (RECA) scheduled to expire in July 2022, eligible uranium miners, millers and ore transporters must file a claim under Section 5 of RECA before the deadline in order to have the opportunity to automatically qualify for EEOICPA benefits. It is therefore our recommendation that additional outreach efforts be undertaken to inform these populations of workers or their surviving family members of the deadline by which they must file a claim for Section 5 RECA benefits, as the award of Section 5 RECA benefits directly impacts the ability of these individuals to receive benefits under Part B and/or Part E of the EEOICPA.

2. Medical Bill Issues: Claimants and providers with medical billing issues should be quickly directed to someone who can assist them in resolving their issues. The claimants and providers who approached us with medical billing issues usually did so after their efforts to work with DEEOIC and/or DEEOIC's medical bill contractor proved unsuccessful. In most instances, when we forwarded the issue to DEEOIC, the medical bill issue was eventually resolved. DEEOIC needs to ensure that there is an effective way to promptly direct those with medical billing issues to the personnel who can assist them.

When medical bill issues arise, claimants and providers need better guidance and assistance. Many of the medical bill issues that we encountered involved “coding problems.” In our experience, simply informing the claimant or provider that there was a coding problem did not provide the claimant or provider with the information needed to resolve the problem. Rather, claimants and providers often needed to be directed to someone who could explain why the code was wrong and the steps to fix it.

In addition, resolving medical bill issues often required explaining the matter to those who were in a position to resolve the issue. The claimants who approached us with medical bill issues often found it frustrating to be placed in the middle of a dispute between DEEOIC and the provider. Thus, in contacting our Office, claimants with medical bill issues oftentimes were simply looking for a way to get DEEOIC and the provider to talk to each other, as opposed to using the claimant as the intermediary. Where appropriate, more effort needs to be undertaken to work directly with the provider to resolve coding problems and other medical bill issues.

3. Medical Treatment Issues: The barriers and limitations placed on in-person medical treatment as a result of the COVID-19 pandemic further brought to light concerns regarding medical treatment issues that claimants and health care providers also brought to our attention under other circumstances. Namely, the need for DEEOIC to move quickly to update its policies and notify claimants and health care providers of policy changes in a timely fashion. Both claimants and health care providers contacted us inquiring about the availability of telemedicine in early 2020, and our efforts to find information on this subject indicated that DEEOIC had not taken steps to implement this option for claimants as quickly as some other federal programs. However, DEEOIC did implement telemedicine as an option for medical treatment and for physician appointments to support authorization for in-home health care.

In 2020, other claimants experienced delays in the authorization for medical treatment and/or home health care where the delays were either unexplained, or were due to the DEEOIC Medical Director’s involvement in individual claims. We generally found that when we contacted DEEOIC regarding a specific issue experienced by an individual claimant, DEEOIC was responsive. Yet, we were rarely provided an explanation to share with the claimant regarding why they had experienced the delay. An explanation is certainly not required in all cases, but part of many claimants’ requests for assistance from our Office included a desire to understand what, if anything, they could do differently to move their request for medical treatment through the process more efficiently.

Also, when contacting DEEOIC by phone, some claimants did not know the role of the person they spoke with and whether that person had the authority to assist them with their problem. Some claimants who contacted our Office for information and assistance did not understand the differences between the Resource Center staff who answered their calls, their claims examiner, the medical benefits examiner, and/or the staff for the medical bill contractor. Up until the point that a claim is accepted, claimants are most often in

communication with Resource Center staff and their claims examiner. However, after a claim is accepted, a medical benefits examiner may need to adjudicate a claim for medical treatment, and claimants have complained that they are confused by the MBE's role and scope of authority.

Likewise, DEEOIC needs to ensure that it has procedures in place to effectively address emergency situations. A frequent complaint concerns the inability to immediately talk to the medical benefits examiner, or other DEEOIC personnel. While as a general rule this can be frustrating to claimants, it is particularly problematic when time is of the essence. In 2020, we were approached by claimants who found it difficult to communicate with DEEOIC in such situations. If claimants are to use the EEOICP medical benefits card for medical services/treatment related to the covered illness, there should be procedures in place to address problems that may arise. And more importantly, there need to be procedures to address situations where time is of the essence. A claimant should not be denied a medical procedure because his/her doctor cannot get a telephone call through to DEEOIC, nor should a hospital have to use our Office as an intermediary because they were unable to get through to anyone at DEEOIC.

4. Difficulties Understanding the EEOICPA Claim Process: More effort needs to be taken to explain this program and answer questions about it. DEEOIC should be commended for the efforts that it has undertaken to disseminate information about the program. However, much of this information is found online, thus limiting its use by those who have limited or no access to the internet. And while DEEOIC also disseminates information at outreach events, access to this information is generally limited to those who attend the events.
 - a. We reiterate our recommendation that DEEOIC explore other ways to disseminate information about this program, and in doing so explore ways to disseminate information to those with limited or no access to the internet, as well as those who do not live near the locations where outreach events are held.
 - b. Many of the claimants we encountered either do not have an Authorized Representative (AR), or their AR is a family member who, along with the claimant, are unfamiliar with the EEOICPA. Thus, we frequently encountered claimants who, because they did not understand this program, proceeded through the adjudication process blindly doing what they were instructed to do, or worse, at each step of the claims process, they struggled to determine what needed to be done. When they had questions, these claimants needed to be able to talk to someone who could provide clear and accurate guidance. In spite of the efforts undertaken by DEEOIC to ensure that telephone calls are answered, we continued to be approached by claimants who told us that when they contacted DEEOIC their messages were not returned, or they were unable to talk to anyone who could assist them. In 2021, our Office will continue to monitor these complaints.

- c. The assistance provided by the Resource Centers also continues to be an area of concern. We talked to claimants who complained about the lack of assistance provided by some of the personnel at the Resource Centers. In 2021, this Office will continue to explore the level of assistance provided by the Resource Centers. DEEOIC should also review and evaluate the assistance offered by its Resource Centers. In this regard, it is clear that the Resource Centers do offer assistance. Rather, the issue is the nature and extent of the assistance offered.
5. Issues Related to Impairment Claims: In previous Annual Reports to Congress, complaints regarding claims for impairment benefits have largely been due to: a) claimants' lack of awareness that they must file a claim form each time they wish to claim impairment benefits; b) difficulties claimants encountered attempting to find a qualified physician to perform their impairment evaluation; or, c) claimants' lack of awareness that they could file for increased impairment benefits every two years.

In 2020, confusion surrounding the circumstances under which a claimant could be granted an exception to the two-year rule between impairment evaluations was brought to our attention. The complaint presented both substantive and procedural questions regarding how and when DEEOIC would allow a claimant to receive an increased impairment award within two years of the prior award. And in one case, the issue was further complicated by the claimant's accepted covered illnesses belonging to the same body system. It was apparent based upon our discussions with the claimant's AR and upon review of claim file information that some DEEOIC staff would benefit from further guidance on these topics. Not only would additional training assist in specific cases such as the ones reported to our Office, but would also likely result in greater consistency among impairment claims where claimants are seeking increased impairment benefits.

We were also presented with a number of complaints regarding the involvement of the OWCP Medical Director in the adjudication of individual impairment claims. The complaints stemmed from the Medical Director's involvement in rejecting the opinion of the physician chosen by the claimant to perform their impairment evaluation, and sometimes included the Medical Director's instruction to have the claim referred to a CMC for impairment evaluation instead. At least one AR complained to our Office that in such circumstances the CMC usually agreed with the opinion of the Medical Director and provided an impairment rating consistent with the Medical Director's opinion. In another instance, the complaint was that this process occurred without a written report by the Medical Director being provided to the claimant or the physician chosen by claimant to provide their impairment evaluation.

We are concerned if claimants and/or their ARs are not being provided the reports prepared by the Medical Director when the opinion of the Medical Director is being considered as evidence in individual claims. It would be helpful to claimants and their ARs to understand the role of the Medical Director in such instances, and to be provided notice and a timeline by which reviews by the Medical Director are being conducted in individual claims. While

such reviews do not appear to be happening in all impairment claims where claimants have chosen their physician to perform their impairment evaluation, at least one physician complained to our Office that the majority of his/her impairment evaluation reports were being scrutinized and rejected by the Medical Director. The physician stated the desire to understand why his/her impairment evaluation reports were being rejected, and claimed to have not received a response from the Medical Director. At a minimum, it would be helpful to claimants and the physicians performing impairment evaluations for them to have a full explanation regarding why the reports are being rejected, sometimes even after the physician provides an amended report.

6. Customer Service, Delays, and Other Administrative Concerns: DEEOIC should review its procedures to ensure that when a claimant leaves a message, someone responds to that message as quickly as possible. And in that regard, when DEEOIC personnel indicate that they have returned a call, the question remains as to whether they actually spoke with the caller or were simply leaving a message for the caller. In comparing DEEOIC's reported high rates of returned calls to the nature of the complaints we received, it appears many calls are likely reported as returned without having spoken to the caller. The ensuing phone-tag between callers and the DEEOIC or RC staff can sometimes drag out for an extended period of time when DEEOIC or the RC staff take 48 hours to return each call. It would perhaps be helpful for DEEOIC to provide guidance or track when DEEOIC or RC staff connect with and speak to the person who left a message.

In addition, it has been our experience that questions asked by claimants cannot always be fully answered on the spot. Rather, research and review is sometimes required before a full answer can be provided. Thus, where review/research is necessary before an answer can be given: (1) how promptly does claimant receive a response; and (2) will someone be available for any follow-up the claimant may have?

Rude or insensitive comments can impact how a claimant ultimately evaluates this program. In this regard, we have talked to claimants with accepted claims who nevertheless had a negative opinion of this program due to rude or insensitive comments directed to them by DEEOIC personnel. And while DEEOIC has expressed its commitment to good customer service, we continue to be approached by claimants who complain of rude or insensitive comments. We have long believed that it would be best if DEEOIC could hear directly from those who encounter what they believe are rude or insensitive comments. Yet, most claimants are reluctant to contact DEEOIC directly with such complaints. Claimants generally believe it is not in their best interest to complain to DEEOIC about the conduct of its staff. If DEEOIC is interested in hearing these complaints, it needs to develop a procedure that claimants feel comfortable using. We continue to believe that a single point of contact for complaints concerning poor customer service would encourage claimants to contact DEEOIC, and would especially be effective if claimants were aware that this point of contact was specifically designated to receive such complaints and was not otherwise involved in the adjudication of their claim. Moreover, recording DEEOIC and RC telephone

conversations is an alternative that may serve as both a check and deterrent to the behaviors that claimants and their ARs have complained about.

7. Other Complaints in 2020: Claims examiners frequently request input from industrial hygiene contractors and contract medical experts during the claims adjudication process.³ The IHs and CMSs do not meet in-person with claimants, but are provided documents from the claim file and questions to answer from the CE. Referrals to the IHs are to be reviewed by DEEOIC's Medical, Health and Science Unit (MHSU), and the IH reports, as well as CMC reports, are to be reviewed by the CEs. The expert opinion reports are to be reviewed for accuracy and completeness.⁴

When the information in the referrals are not accurate, or when the reports drafted by the experts are not accurate, it is incumbent upon the CE to identify and take appropriate action to address any inaccuracies or deficiencies. In 2020, complaints were raised regarding the issue of whether the review of referrals to IHs and the reports drafted by IHs and CMCs were being adequately performed. Instances were brought to our attention of incorrect information being supplied to IHs and CMCs. It is our recommendation that DEEOIC undertake additional efforts to review the accuracy of the referrals and expert opinion reports, perhaps by having supervisory staff more closely review the referrals and reports. We make this recommendation, in part, because claimants and their ARs are not routinely provided copies of the referrals and reports to review prior to them being relied upon in a recommended and/or final decision. In one of the examples included in this year's report, the claimant was immediately able to identify the error regarding his/her use of personal protective equipment on the job, but the error was not identified until after the claimant received a Recommended Decision to deny his/her claim.

A further recommendation is to provide claimants and their ARs with copies of the referrals to and reports by IH and CMC contractors prior to the issuance of a recommended decision. Claimants often are unaware that their claim may be forwarded to an IH or CMC for review, and also do not know that if they submit a written request for this documentation, it can be sent to them. Because it is often these reports that form the basis for DEEOIC's decision to accept or deny a claim, it is our recommendation that claimants automatically be provided the referrals to and expert opinion reports from IHs and CMCs as they are written. By receiving the referrals and expert opinion reports as they are written, versus after the

³ In fiscal year 2019, DEEOIC reported making 1,795 referrals to Industrial Hygienists and 2,634 referrals to CMCs. See DEEOIC's Response to the 2019 Annual Report to Congress, page 6. (January 15, 2021).

⁴ Upon review of the IH referral by the MHSU, if the referral is found deficient and warrants additional review or development, the referral is returned to the CE for additional action. PM Chapter 15.11(c), Version 4.3 (September 14, 2020). Upon receipt of the completed IH response, the CE images the response and moves forward with the claim based on the outcome. PM Chapter 15.11(f), Version 4.3 (September 14, 2020). Once the [CMC] medical report is downloaded, the CE reviews it for accuracy and completeness. The review should include the CMC's interpretation of test results, evaluation of medical reports submitted for review, answers to each question posed, and the CMC's rationale showing how his or her opinion is supported by the evidence in the file. PM Chapter 16.13(a), Version 4.3 (September 14, 2020).

Recommended Decision has been issued, claimants have the ability to timely review and/or refute the referrals and reports before they are relied upon in a decision.

TABLES

The Office of the Ombudsman is required to submit to Congress an Annual Report that sets forth: (1) the number and types of complaints, grievances, and requests for assistance that we receive in the preceding year, and (2) an assessment of the most common difficulties encountered by claimants and potential claimants received in the preceding year. 42 U.S.C. § 7385s-15(e)(2). Setting forth the number and types of complaints, grievances, and requests for assistance that we receive in the calendar year is often a challenge. First, each claimant we encounter comes with their own unique set of problems which they articulate to us in their own unique manner. Under these circumstances identifying the type, or nature of a complaint, can be challenging since claimants rarely express their concerns using the terms and phrases commonly utilized by those who administer the program.

Second, the Office typically attends 20-25 in-person outreach events each year, and at those events we hear from many potential claimants, claimants, authorized representatives (AR), and health care providers. Meeting in person affords us the time to connect with individuals and hear not only their initial questions or concerns, but their whole story, which frequently reveals additional questions and/or concerns. During 2020, as a result of all in-person outreach events being cancelled, our opportunities to connect with and to assist the claimant community at in-person outreach events was severely limited.

Moreover, when our Office hosts in-person outreach events, we routinely provide notice to those living in a large geographical area around each event location. While those who live farther away from the event location may not be able to attend the event itself, we have found that many people contact our Office by telephone or email after receiving notice of the event. And it is in these conversations that we also hear the questions and complaints of claimants in that particular area of the country. Unfortunately, the inability of our Office to attend or host in-person outreach events had an impact on the number of individuals we communicated with and assisted in 2020.

Furthermore, identifying the specific complaints, grievances, and/or requests for assistance raised by claimants is generally achieved by asking questions, and obtaining additional documents that shed light on the claimants' concerns. In the table that follows, the focus is on the concerns or requests that prompted the claimant to contact us, not every issue that was discussed in the conversations that ensued in order to provide the claimant with a full understanding of the EEOICPA and the EEOICPA claims process.

TABLE 1 – COMPLAINTS, GRIEVANCES, AND REQUESTS FOR ASSISTANCE BY NATURE OF COMPLAINT

NATURE OF COMPLAINT	Number
Difficulties collecting records/evidence	
General complaints	6
Employment records	11
Exposure records	11
Concerns with the dose reconstruction	6
Concerns with information found in SEM	3
Difficulties establishing terminal status	9
Difficulties establishing causation	16
Request for assistance	55
Needs more explanatory materials from DEEOIC	29
Request for status of claim	9
Issues involving interactions with staff of DEEOIC	
General	3
Telephone calls not returned/cannot get through	34
Rude and/or insensitive behavior	15
Complaints involving claims for impairment or wage-loss	11
Complaints regarding DEEOIC's hearing loss policy	4
Complaint concerning the cap on benefits	1
Requests for assistance with issues concerning RECA claims	2
Medical Benefits	
Difficulties obtaining authorization for and/or complaints regarding the denial of a requested medical benefits	12
Issues involving home health care benefits	16
Complaints alleging a delay in the processing of a claim	20
Claimant needed assistance verifying that he/she was a covered employee or worked at a covered facility	8

Difficulties establishing survivor eligibility	6
Difficulties establishing eligibility in a SEC class	4
Difficulties obtaining payment of a medical bill	40
Difficulties with use of medical benefits card	5
Difficulties establishing diagnosed illness/consequential illness	4
Just learned of program, need to file a claim	7
Coordination and/or offset of benefits	1
Reopening/Reconsideration issues	4
Take home toxins	3
Tax issues	3
Death prior to award of benefits	2
Miscellaneous statutory and regulatory concerns	8
Miscellaneous	69
TOTAL	441

TABLE 2 - COMPLAINTS BY FACILITY

In order to assist claimants, it is not always necessary to identify the facility where the worker was employed. Moreover, even when identifying the facility is necessary, this does not suggest any fault on the part of the facility. Rather, the intent of the Table of Facilities is to illustrate the reach of this program and the need for more outreach. Claimants who worked at facilities all across this country contact us with complaints, grievances, and requests for assistance. Some of the facilities on this Table employed large numbers of employees, while others employed smaller numbers. Some operated as covered facilities for many years, while others engaged in covered employment for a relatively short period of time. Yet, regardless of the size of the facility or the number of years it operated as a covered facility, there are those who work, or once worked, at these facilities, who have questions and concerns that need to be addressed.

FACILITY	LOCATION	NUMBER OF COMPLAINTS
Albany Research Center	Albany, OR	1
Allied Chemical Corporation Plant	Metropolis, IL	2
American Beryllium Co.	Sarasota, FL	1
Ames Laboratory	Ames, IA	1
Area IV OF The Santa Susana Field Laboratory	Santa Susana, CA	8
Feed Material Production Center	Fernald, OH	4
General Electric Company	Cincinnati/Evendale, OH	1
Hanford	Richland, WA	13
Idaho National Laboratory	Scoville, ID	5
Iowa Ordnance Plant	Burlington, IA	2
Kansas City Plant	Kansas City, MO	4
Lawrence Livermore National Laboratory	Livermore, CA	6
Linde Ceramics Plant	Tonawanda, NY	1
Los Alamos National Laboratory	Los Alamos, NM	12
Mound Plant	Miamisburg, OH	8
Nevada Test Site	Mercury, NV	8
Nuclear Materials and Equipment Corporation	Parks Township, PA	1
Oak Ridge	Oak Ridge, TN	11
Oak Ridge Gaseous Diffusion Plant (K-25)	Oak Ridge, TN	2
Oak Ridge National Laboratory (X-10)	Oak Ridge, TN	1
Oak Ridge Y-12 Plant	Oak Ridge, TN	14
Paducah Gaseous Diffusion Plant	Paducah, KY	7
Pantex Plant	Amarillo, TX	4
Pinellas Plant	Clearwater, FL	1

Portsmouth Gaseous Diffusion Plant	Piketon, OH	4
Rocky Flats Plant	Golden, CO	19
Sandia National Laboratory	Albuquerque, NM	6
Savannah River Site	Aiken, SC	9
Speedring, Inc.	Cullman, AL	1
Tennessee Valley Authority	Muscle Shoals, AL	2
Uranium Millers	Various Locations	1
Uranium Miners	Various Locations	7
Weldon Spring Plant	Weldon Spring, MO	1
Miscellaneous		228

Chapter 1 – Effectiveness of Outreach Efforts

In our 2019 Annual Report to Congress, while acknowledging the efforts undertaken by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) to increase its outreach efforts, we nevertheless recommended that DEEOIC explore and use a variety of approaches in not only continuing, but increasing these efforts. *See*, Office of the Ombudsman's 2019 Annual Report to Congress, July 28, 2020. Consistent with this recommendation, the DEEOIC began calendar year 2020 with plans to hold at least one in-person outreach event each month. In January 2020, the DEEOIC hosted an Energy Outreach event in Kansas City, MO, and in February 2020, the Joint Outreach Task Group (JOTG), of which DEEOIC is a member, hosted both an outreach event and a multi-day Authorized Representative Workshop in Santa Fe, NM.

However, the COVID-19 pandemic upended all plans for in-person outreach events for the remainder of the year. In response, DEEOIC and its partner agencies hosted monthly webinars. These online webinars discussed specific aspects of the EEOICPA, and based upon the feedback received, have been very informative.

In light of the events of the past year, as DEEOIC plans for the future it will be even more critical to explore and use a variety of approaches to disseminate information about this program to claimants and potential claimants. We say this because while the webinars sponsored by DEEOIC were informative, they were also only accessible online. As a result, accessing the webinars was difficult for those with limited or no access to the internet, as well as for those who were unfamiliar with or uncomfortable using computers. It has also been our experience that when potential claimants are not aware of this program, there is little to no chance they will be aware of the website maintained by the DEEOIC, or aware of the webinars sponsored by DEEOIC.

In addition, we have observed that in-person outreach events provide a forum where claimants feel comfortable asking their programmatic or claim related questions. Over the years we have been amazed at the number of claimants and potential claimants who came to outreach events seeking answers to questions, that in our opinion, they could have just as easily posed to the Resource Center and/or District Office.⁵ We do not know why these individuals chose to raise their questions at these events. Yet, based upon our conversations with some of these individuals it is clear that rather than contacting the Resource Center and/or District Office with their concerns, some individuals specifically came to these outreach events to obtain answers to their questions.⁶ If, in the future, there are fewer in-person outreach events, DEEOIC will need to

⁵ It is also not uncommon for individuals to travel several hours by car to attend outreach events.

⁶ Claim specific questions are generally not answered during the public question and answers sessions at outreach events, but are instead answered by claims examiners, Resource Center staff, and the staff of other agencies, including this Office, during one-on-one conversations with meeting attendees.

develop other forums where claimants feel comfortable asking their programmatic and claim specific questions.⁷

These concerns regarding the ability of individuals who worked in our nation's nuclear weapons complex, as well as their families, to learn of the EEOICPA likewise begs the question our Office has raised for a number of years, which is why not reach out to these workers and their families directly via letter? It is one of the most effective ways to reach individuals who have not yet learned of the EEOICPA, and it is our understanding that the DOE Former Worker Medical Screening Program maintains rosters of individuals who were employed at covered DOE facilities. The DOE FWP keeps the contact information for former DOE workers accurate by utilizing address-update services, and according to the 2019 Former Worker Medical Screening Program Report, the rosters are the primary outreach method to reach former DOE workers.⁸ During 2019, for example, DOE assisted DEEOIC with 10 of its outreach events. Our recommendation is for DEEOIC to expand its efforts to directly reach out to those who do not live within the mailing radius for an in-person outreach event by contacting them directly.

Unfortunately, the DOE does not have rosters for those who worked at Atomic Weapons Employer (AWE) facilities, for Beryllium Vendors, and/or for Uranium Mines, Uranium Mills, and Uranium Ore Transporters.⁹ This means that DEEOIC cannot rely upon DOE for assistance in contacting the current and former workers of these 193 AWE facilities, 74 beryllium vendors, and numerous uranium mines, uranium mills, and uranium ore transporters.¹⁰ As such, our Office encourages DEEOIC to continue expanding its outreach efforts directly to those who worked for these employers.

Moreover, with RECA scheduled to expire in July 2022, eligible uranium miners, millers, and ore transporters must file a claim under Section 5 of RECA before the deadline in order to have the opportunity to automatically qualify for EEOICPA benefits. It is therefore our recommendation that additional outreach efforts be undertaken to inform these populations of workers or their surviving family members of the deadline by which they must file a claim for Section 5 RECA benefits, as the award of Section 5 RECA benefits directly impacts the ability of these individuals to receive benefits under Part B and/or Part E of the EEOICPA.

⁷ At the present time, DEEOIC has not revealed to us their outreach plans beyond 2020.

⁸ See 2019 Former Worker Screening Program Annual Report, page 5.

<https://www.energy.gov/sites/prod/files/2019/05/f63/2018-FW-Medical-Screening-Program-Report.pdf>.

⁹ The Radiation Exposure Compensation Act (RECA), administered by the Department of Justice (DOJ), will expire on July 12, 2022. See 71 Fed. Reg. 79118 (December 9, 2020). Uranium miners, millers and ore transporters who automatically qualify for EEOICPA benefits as a result of the acceptance of their Section 5 RECA claim will lose this avenue to have their claim accepted when the RECA statute expires.

¹⁰ The DOE created a Facility List database to provide public access to summaries of information collected on the facilities listed in the Federal Register. The summary for each facility includes the facility name, state, location, time period, facility type, and facility description. <https://ehss.energy.gov/Search/Facility/findfacility.aspx>.

Another concern brought to our attention is that the valuable information shared at these events is sometimes only available to those who attended the events. For example, in February 2020, the JOTG conducted a multi-day Authorized Representative Workshop in Santa Fe, New Mexico. The 35 spots allocated for this event were claimed and a waiting list was created for those who did not secure one of the initial spots.¹¹ We heard from ARs that much of the information shared during the workshop would be useful for them and other ARs should DEEOIC post it online.¹² The DEEOIC website contains numerous presentations from other forms of outreach events, including webinars. Therefore, our recommendation is for the materials from the AR Workshops to be posted on the DEEOIC website and made available in hard copy at the RCs.

¹¹ Approximately 20 people attended the workshop and it was unclear if any of those individuals had been on the waiting list.

¹² AR Workshop attendees are provided binders containing hard copies of the presentations by the various agencies who provide the training.

Chapter 2 – Medical Bill Issues

Claimants with an accepted covered illness under the EEOICPA shall be furnished with the services, appliances, and supplies prescribed or recommended by a qualified physician for a covered illness that the President considers likely to give cure, relief, or reduce the degree or period of that illness. *See* 42 U.S.C. § 7384t(a). The EEOICPA also provides for necessary and reasonable transportation and expenses incident to the securing of such services, appliances, and supplies. *See* 42 U.S.C. § 7384t(c).

Upon acceptance of a claimed medical illness, claimants are mailed a medical benefits card, also known as the “white card”. The card itself contains the claimant’s case number, pharmacy number, and DEEOIC Group ID number, in addition to the link for OWCP’s medical bill processing portal. Claimants and health care providers, once registered, may use the information on the card to access the Workers’ Compensation Medical Bill Process (WCMBP) online portal. This online portal allows the user to verify the accepted medical conditions and their corresponding ICD codes; the authorization history for requested services; the billing history; and the correspondence sent to them by the bill-pay contractor.

In 2019, the EEOICPA claimant community and the medical providers who care for them anticipated improvements when DEEOIC announced that a new medical bill-pay contractor was scheduled to take over the existing contract in April 2020. Claimants were informed that their files would be transferred from the Conduent system to the WCMBP system referenced above without claimant intervention and with no interruption in payments for out-of-pocket expenses. Claimants were further informed that bill history data for the past 7 years would be viewable and all historical bills would transfer from the Conduent system to the WCMBP system. Finally, claimants were informed a letter would be mailed to them before April 27, 2020 introducing CNSI, the new bill processor, and the WCMBP system features applicable to claimants. The claimant’s new medical benefits card was also to accompany this letter. *See* April 15, 2020 webinar, Updating Claimants. As part of the transition from Conduent to CNSI, the mailing address for paper bill submissions was changed from an address in London, KY to San Antonio, TX. Unfortunately, the transition did not go as smoothly as anticipated for all claimants and providers.

A. Complaints Related to the Medical Billing Contractor Transition

DEEOIC announced the transition of medical bill-pay contractors in 2019 and by early 2020 it was clear that much effort had gone into informing claimants and health care providers as to what they could expect before, during and after the transition. Prior to the effective date of this transfer on April 27, 2020, all eligible claimants were to receive a new medical benefits card. Yet, on April 28, 2020, an advocate informed us of twenty (20) individuals who had not received the new card. For some claimants, instead of

receiving a DEEOIC medical benefits card, they received a medical benefits card for the Black Lung workers' compensation program. Claimants who received the Black Lung medical benefits cards contacted our Office when they were uncertain who to contact in order to have the correct card sent to them, and/or when they experienced difficulties connecting with someone who could assist them. In other instances, family members of deceased claimants shared their frustrations with our Office when they received a medical benefits card for their deceased loved one.

For those who received their medical benefits card in an untimely fashion, or received the wrong medical benefits card, any concerns they harbored around the transition from one billing contractor to another raised immediate concerns. Claimants understood that every person receiving medical benefits under the EEOICPA was subject to this process, yet there were not provided information regarding whether their problems were isolated or were impacting everyone who was entitled to receive medical benefits. In an effort to obtain assistance, some claimants who attempted to contact the new contractor by telephone reported they were unable to speak with anyone. Other claimants who had to call more than once before receiving a return call eventually contacted our Office for assistance when they had another issue or question. It is our understanding that claimants were ultimately sent the correct medical benefits cards, and by June the complaints from claimants who had not received their new medical benefits card or received a card that mistakenly identified them as a Black Lung recipient had subsided.

Another set of complaints brought to our Office involved the WCMBP online portal. Claimants complained of logging into the portal to find a blank screen, missing information, and/or erroneous information. We were informed of instances where the claimant's name and social security number were wrong; covered illnesses and ICD codes were not populated in the portal; and the names of the claimants' health care providers were not on the Bill Pay Inquiry Page. One particular claimant who contacted our Office in late June stated that he/she had been experiencing problems with the portal for months. He/she complained that when they logged into the portal the screen was blank, and despite calling for assistance and being told the problem had been sent to Technical Support, the problem had not been resolved.

By the end of July, some claimants were raising a new concern. As part of the initial transfer to the new bill pay contractor, DEEOIC announced that medical bills should no longer be sent to the P.O. Box address in London, KY. Rather, effective April 27, 2020, medical bills were to be forwarded to a P.O. Box in San Antonio, TX. Nevertheless, approximately three months after the April notice, DEEOIC announced that effective July 20, 2020, there would be a second new mailing address for the submission of medical bills. The new mailing address was a P.O. Box in London, KY. This change from a P.O. Box in London, KY, to a P.O. Box in San Antonio, TX, and then back to a P.O. Box in London, KY, confused some claimants and health care providers. What troubled some

claimants even more was the statement in DEEOIC's notice which indicated that during the transition any mail sent to San Antonio would be forwarded to London, KY, and this would delay processing. We subsequently spoke with a couple of claimants who were not happy when they discovered that, after following instructions and sending medical bills to San Antonio, the processing of their claims were now delayed.

Additional confusion was added by the fact that while CNSI is the new medical bill contractor, the previous medical bill contractor, Conduent, remained the billing contractor for prescription medication. Generally speaking, for those whose claims have been accepted, the promise of medical treatment without co-payments and co-insurance payments brings immense relief. But when the process by which those benefits are provided do not function properly, even for just a period of time, claimants and their ARs have expressed the need for greater communication, information, and resolution of their problems. It is unclear what actions were taken by DEEOIC, or their contractor, to acknowledge in a timely way the various issues that impacted the transition of medical bill contractors, or to provide information directly to claimants regarding the process for resolving the issues. The claimants and authorized representatives (ARs) who filed complaints with our Office stated that they did not fully understand what was happening; who to seek information and assistance from within DEEOIC and CNSI; and that when they contacted the toll-free telephone numbers provided by DEEOIC and CNSI they were unable to speak with someone who could assist them.

B. Difficulties Obtaining Assistance with Medical Billing

Over the years we routinely encountered potential claimants who first became aware of this program when they were informed of or attended an outreach event. However, due to the pandemic, the various agencies involved with the administration of EEOICPA, as well as other interest groups, significantly reduced the number of in-person outreach events held in 2020. As a result, in 2020 we did not encounter many potential claimants who had just learned about the program and were now seeking more information. Instead, the bulk of our contacts were from claimants who had questions about a claim or were seeking assistance. One of the more frequent reasons claimants turned to us for assistance was when they were unable to resolve medical billing issues.

In 2018, DEEOIC created a new Branch of Medical Benefits Adjudication and Bill Processing Unit (Medical Benefits Branch), staffed by medical benefits examiners who are experts in medical authorization and billing. *See* DOL's Response to The Office of the Ombudsman's 2017 Annual Report to Congress, No. 4 (March 26, 2019). This new branch has allowed for the greater specialization among those who work for DEEOIC, and the intent clearly is to provide, in part, more focused attention on particular aspects of the adjudication process and delivery of benefits to claimants.

Prior to the creation of this Medical Benefits Branch, claimants often turned to us for assistance with their medical billing issues after their efforts to work with DEEOIC and/or its bill processing contractor to resolve the matter were unsuccessful. In our experience, when the matters brought to our attention were forwarded to DEEOIC, in most instances the matter was eventually resolved.¹³ Thus, when DEEOIC announced the creation of this new Medical Benefits Branch, we hoped to hear from fewer claimants seeking information and assistance with medical billing issues. However, in 2020, claimants continued to contact us with medical billing issues, and continued to contact us after their efforts to resolve the matter by working with DEEOIC and/or its medical billing contractor were unsuccessful.

Dr. [Smith] in Oak Ridge Tn [sic] is my provider and they have my DOL card but they bill medicare [sic]. I just wanted you to know. I have two providers that are mine have quit. They told me they could not get payment. I would like you to investigate what is going on and report this problem to congress [sic]. This [is] not fair I have been approved but doctors will not bill because of all the hassles.

- Email from claimant, September 2020

In one instance our Office heard from a claimant whose request for reimbursement for certain medical services was approved on August 29, 2019. When the claimant initially contacted us in 2019, in addition to complaining about the delay in receiving the reimbursement, the claimant was also troubled by the difficulties he/she encountered trying to communicate with DEEOIC, a problem exacerbated by the fact the claimant was not living in the United States.¹⁴ We thought this matter was addressed in 2019, however in March 2020 the claimant again contacted us continuing to complain of not receiving the reimbursement. We again forwarded the matter to DEEOIC. The matter was finally resolved in September 2020.

In another instance, when a claimant initially approached us, the claimant had questions about a remittance form he/she had received. Our review of the form prompted further discussions with the claimant which revealed the claimant had been waiting so long for DEEOIC to respond to his/her request for reimbursement that the claimant feared the request had been denied. These discussions also revealed that the claimant called our Office after calling the telephone number on the back of the DEEOIC medical benefits card and not receiving a response to the message he/she left. In response to our inquiry, a

¹³ Resolving the most challenging medical billing issues often required the assistance of DEEOIC and/or its medical billing contractor working directly with the billing office for the health care provider.

¹⁴ The banking institution the claimant designated to receive the funds was in the United States. However, DEEOIC explained that in many instances, the services received by claimants not living in the United States were paid under a foreign currency which required conversion, and since they did not have a domestic zip code, the bill pay contractor could not apply the OWCP fee schedule, thus requiring that the matter be handled outside of the system.

representative from DEEOIC contacted the claimant to explain that the requests for reimbursement had been processed and to assure claimant the reimbursements were forthcoming. In this conversation, the claimant was also invited to directly follow up with DEEOIC on four (4) other pending requests for reimbursement. In spite of the invitation to directly follow-up with DEEOIC, the claimant chose to follow up with our Office about these other outstanding requests for reimbursement. We forwarded this subsequent inquiry to DEEOIC and in response we received an email explaining why each of the four requests had not been processed. When we contacted the claimant to tell him/her what we had learned, it quickly became evident that claimant had not received anything in writing from DEEOIC informing or explaining to him/her why these requests had not been processed. When we brought this to DEEOIC's attention, DEEOIC immediately contacted the claimant to discuss why these requests had not been processed.

In yet another instance, a claimant contacted us when he/she did not receive the reimbursement that had been authorized because the reimbursement from DEEOIC was sent to an account that had been closed. In contacting our Office, the claimant maintained that he/she had been trying to resolve this matter for two (2) months and was quite upset because of the difficulties encountered trying to talk to someone associated with DEEOIC about this matter. Since our Office did not have a signed and dated Privacy Act Waiver from this claimant, we simply forwarded the matter to DEEOIC's attention.¹⁵ Three months later, the claimant again contacted us when the matter had not been resolved. This time, after bringing the matter to DEEOIC's attention, it was finally resolved.

In March 2020, a claimant with an approved retina condition reached out for assistance after the DEEOIC had paid the claimant's physician for the office visits and medical procedures, but not the medication provided as part of the procedures. The claimant indicated that he/she had been working with the billing contractor to try to resolve the issue without success. Increasing the claimant's concern was the suggestion that he/she pay the outstanding bill and seek reimbursement from DEEOIC. However, the claimant reported that he/she did not have \$8,000 to pay for the medication, and he/she needed this treatment on a somewhat routine basis. The provider threatened to send the bill to Medicare for payment and the claimant described feeling helpless to stop the provider from doing so.

Another claimant summarized the issues he/she had experienced over six and one-half months trying to obtain reimbursement for out-of-pocket medication expenses. During

¹⁵ In order to seek any information regarding a DEEOIC claim, our Office is required to obtain a signed and dated Privacy Act Waiver from the claimant or their AR and provide it to DEEOIC. Since we did not have a Privacy Act Waiver signed and dated by the claimant, DEEOIC did not discuss this claim with us. Instead, we hoped that DEEOIC would directly work with the claimant to resolve his/her concerns.

the time that it took him/her to obtain reimbursement, he/she reported making tens of calls to the new medical bill contractor, and over 40 calls to DEEOIC and our Office. He/she also inquired as to whether there might be an opportunity for someone in DOL to review his/her case so that the systemic issues and root causes of the deficiencies could be identified and solutions put into place within DOL and CNSI to prevent other claimants from going through a similar experience. In closing, the claimant wrote, “I also will have to start this process all over again with my annual meds with a new medical benefits claim, and I certainly never want to go through such an experience ever again.”

Complaints regarding medical billing were not limited to claimants. For example, an assisted living facility complained that they had been attempting for nearly 8 months to become enrolled as a provider and register appropriate billing authorizations necessary to submit claims for a claimant. The provider indicated that one claimant had accrued a balance in excess of \$100,000 while the provider was unable to submit claims due to its inability to receive the necessary services from the DOL. In addition, the provider stated,

We are consistently rerouted and ignored when we call various DOL contact lines or when we leave voicemails requesting return calls. Most recently, we submitted all the necessary paperwork for billing authorizations as directed by a DOL employee and faxed them as directed on [date]. We have not received any confirmation or update or denial or notice of any kind with regard to these submissions. We have attempted to reach out to DOL several times since then to request status of these three billing authorization applications but have received no response.

- Email from medical provider, April 2020

Our Office also received a request for assistance and was provided copies of billing invoices from a dental practice for over \$8,000 in unpaid bills related to covered treatment for claimants rendered from 2018 through 2020. The medical provider explained that they were not as familiar with the billing practices and forms used by DEEOIC, and that it had been four months since they were last able to communicate with the person they had previously spoken with at the DEEOIC Resource Center. The medical provider stated that several messages had been left but no one had called them back. We forwarded the billing invoices to DEEOIC and approximately seven months later were informed that DEEOIC and the medical provider were still working through the billing issues, with some of the outstanding billing issues having been resolved.

C. Inadequate Assistance with Medical Bill Coding Issues

In approaching our Office for assistance with a medical billing issue, claimants sometimes complained about the assistance, or lack of assistance, provided by DEEOIC

and/or its medical billing contractor. As noted in the examples above, in some instances claimants complained that DEEOIC and/or its medical billing contractor did not respond to their requests for help. In other instances, claimants questioned the adequacy of the assistance they received from DEEOIC and/or its medical billing contractor.

For example, a claimant contacted our Office when DEEOIC paid for certain aspects of the treatment he/she received, but did not pay for other aspects of the same treatment. When the claimant contacted our Office, he/she had already spoken to DEEOIC and understood that there was a “coding problem.” The claimant contacted our Office when he/she did not get assistance from DEEOIC in resolving the problem.

Very often the Doctor [*sic*] puts the wrong Code [*sic*] on my claims even after I have been there several times and they have made out claims correctly. On 5/02/2019, I went to a pulmonary specialist whom I have seen for many years. He put the correct code on the office exam but sent me to another room for an x-ray but put the wrong code on the claim for that.

...I called [provider’s] billing and told them of the billing error and they checked with the DOL claims office and were told that DOL Claims do not allow rebilling for claims submitted with the wrong codes. If that is the case, I will be in real trouble using this insurance since I have no control over Dr [*sic*] office billing.

- Email from claimant, April 2020

In fact, in 2020, multiple claimants complained of encountering difficulties in trying to resolve coding problems. From what we can tell, coding problems arise when DEEOIC or its contractor rejects the billing code used by the provider to identify and/or to bill for a medical service/procedure. Because claimants are usually not responsible for entering codes, and are not in a position to change codes, they need input from DEEOIC, DEEOIC’s billing contractor, and/or the health care provider to resolve these problems. When they encounter difficulties trying to obtain input/assistance from DEEOIC, the billing contractor, and/or the provider some claimants turn to our Office. Below is a common scenario that we see.

As the result of a coding problem, DEEOIC had not paid a bill submitted by an enrolled provider, and had not reimbursed a claimant for out-of-pocket expenses.¹⁶ Eventually, as a result of the lack of payment, the provider: (a) initiates a collection action; (b) terminates services/treatment to the claimant; or (c) both a and b. At this juncture, if the claimant has not already done so, he now feels compelled to intervene in an effort to

¹⁶ The description “enrolled provider” means that the health care provider (i.e., doctor, hospital, pharmacy, home health care provider, etc.) has completed the necessary forms to receive direct payment from EEOICP for services rendered to claimants.

ward off a collection action; to continue to receive services/treatment from the provider; or both. However, in attempting to resolve the medical billing issue, claimants often find themselves caught in the middle. When they approach DEEOIC about the issue, they may be informed that the provider used the wrong code. Yet, when claimant informs the provider that, according to DEEOIC, the wrong code was used, the provider does not necessarily understand the nature of the error or is equally insistent they are using the correct code. There is little wonder that when claimants contact us with medical billing issues, they often express frustration with the back and forth they had to endure, and are looking for a way to prompt DEEOIC to directly contact the provider to resolve the matter. It has been our experience that medical billing issues forwarded to DEEOIC were usually resolved, and we are aware of a few instances where the matter was resolved when DEEOIC directly contacted the provider.¹⁷

The adequacy of the assistance provided by DEEOIC was clearly questioned by a claimant who, in contacting us, conceded that DEEOIC had already taken steps to ensure the payment of the outstanding medical bill. Yet, although the pending bill had been paid, the claimant questioned whether DEEOIC had taken sufficient steps to ensure that the same coding problem would not occur again. Noting that the problem arose when the provider entered a code that DEEOIC would not accept, the claimant questioned whether DEEOIC had talked to the provider to ensure that the provider would not use the incorrect code when billing for future services/treatment.¹⁸

The belief that talking directly to the provider was the most effective way to resolve medical billing issues was also expressed by a claimant who, before contacting our Office for assistance, had tried to resolve the matter on his/her own. This claimant asserted that for approximately seven (7) years, he/she had not encountered any problems with the payment of medical bills. However, this changed following DEEOIC's announcement of the move from ICD-9 to ICD-10 codes.¹⁹ This claimant contended that after this change, coding problems started to hinder the payment of some medical bills.

When the claimant contacted us in 2020 because of a coding problem, he/she had already attempted to resolve this matter by speaking directly to the provider. Unfortunately, claimant's calls to the provider were directed to the billing department and the billing

¹⁷ In many instances, we were made aware the matter was resolved, but do not know what steps were taken to resolve the matter.

¹⁸ Claimants feel that DEEOIC is better situated to explain to providers why the code was not correct. In addition, DEEOIC can inform the provider of the correct code to use.

¹⁹ ICD is a statistical classification and coding system used to assign appropriate codes for signs, symptoms, injuries, diseases, and other medical conditions. The transition to ICD-10-CM was federally mandated for all Health Insurance Portability and Accountability Act (HIPAA) covered entities. ICD-9-CM reported non-specific data about a patient's medical conditions and hospital inpatient procedures, while ICD-10-CM allowed for greater specificity and accuracy when reporting diagnoses. *See*, ICD-10-CM Transition, Train the Trainer Reference Guide, found online in the EEOICP Public Reading Room. In the instant case, the claimant felt that the "coding problems" he/she encountered were the result of the greater specificity allowed by ICD-10-CM.

department repeatedly informed claimant that they simply prepared and mailed bills, they did not enter the codes. Hoping for a better result, claimant attempted to arrange a three-way telephone call between the claimant, a representative from DEEOIC, and a representative from the provider. However, even with DEEOIC's participation, the claimant was only able to speak to the provider's billing department and nothing was accomplished. With the matter still unresolved, the claimant contacted our Office. In response to our inquiry to DEEOIC, we were informed that the medical bill had been adjusted and the provider would receive payment.

In his/her complaint to our Office, this claimant also complained that DEEOIC did not inform him/her when the problem first arose with the bill. We frequently hear this concern. Although the medical provider directly submits the bill to DEEOIC for payment, claimants complain of being caught off guard when they learn their medical bill(s) have gone unpaid for what is sometimes an extended period of time. Claimants assert that it causes their stress levels to rise, and/or describe the embarrassment they endure when they only become aware of an unpaid bill when they receive a collection notice or are otherwise approached by the provider about the lack of payment.

Chapter 3 – Medical Treatment Issues

For those without health insurance, and even in some instances for those with health insurance, the receipt of medical benefits under the EEOICPA brings the promise of one less concern while they receive medical care for their covered illness. A claimant in receipt of medical benefits is afforded payment for the treatment of their covered illness without having to pay the deductible or co-insurance payments associated with most health insurance plans. There are, of course, rules and regulations governing the way this benefit may be used by claimants, including pre-authorization for some types of benefits and/or limitations on the quantity of some medical services. However, in large part, the medical benefits and the services available under the EEOICPA are expansive, ranging from doctor's visits to home health care to home modifications and oxygen concentrators.

Similarly, the complaints that claimants, ARs, and health care providers brought to the attention of our Office in 2020 likewise ran the gamut from challenges related to the COVID-19 pandemic; to difficulties finding a health care provider who accepts payment from the DEEOIC; to challenges obtaining authorization for medical treatment and prescription medication. Some of the answers to the most basic questions are available in DEEOIC regulations and policy guidance, and having knowledge of where to find the answers, we share that information with those who contacted our Office. There remain, however, individuals whose circumstances don't neatly fit into the regulatory or policy scheme, and for such individuals, they face additional challenges in their efforts to obtain medical treatment that will be covered by DEEOIC. We often hear from these individuals when they do not understand how to proceed through the authorization process, or when they are unable to make progress on their own and no longer have the resources or energy to both deal with their medical illness and the medical authorization process.

A. Issues Related to COVID-19

COVID-19 affected many aspects of life, including the administration of the EEOICPA program. DEEOIC is to be commended for its efforts to address the problems raised by the pandemic. In this regard, it should be recognized that in response to the pandemic on April 7, 2020, DEEOIC issued guidance recognizing the need to implement temporary procedures to allow for the use of telemedicine in place of face-to-face examinations for home and residential health care (HRHC) and durable medical equipment (DME) evaluations until such time as the pandemic restrictions are no longer necessary and are lifted. *See* EEOICP Bulletin No. 20-03, Telemedicine for HRHC and DME (Effective date: April 7, 2020; Expiration date: September 30, 2020).²⁰ Similarly, on April 30, 2020, DEEOIC issued guidance recognizing the need to implement temporary procedures

²⁰ DEEOIC subsequently issued Bulletin No. 20-06 and Bulletin No. 21-02, which combined to extend Telemedicine for HRHC and DME bulletins through September 30, 2021.

to allow for the use of telemedicine in place of nonemergency, routine medical appointments between physicians and claimants until such time as pandemic restrictions are lifted and are no longer necessary. *See* DEEOIC Bulletin No. 20-04, Telemedicine for Routine Physician Appointments (Effective date: April 30, 2020; Expiration date: September 30, 2020).²¹

However, there were instances where individuals expressed the view that DEEOIC's response to the pandemic was another example of its inability to ensure the continued delivery of medical services by quickly responding to emergencies/changes in circumstances. This point was specifically raised by a medical provider who contacted us before the issuance of Bulletin 20-03 or Bulletin 20-04, and who was seeking information regarding whether DEEOIC had addressed the need for telemedicine. In this conversation, the provider noted that other health insurance carriers and medical bill payors he/she worked with had not only developed procedures to address telemedicine as a result of the pandemic, but had also developed and distributed tools to assist providers in providing medical care as a result of the pandemic. It troubled this provider that he/she had not heard or received anything from DEEOIC discussing the pandemic or telemedicine.

Medicare, Medicaid, and the VA have made provisions for their patients [to use telemedicine] and I believe the US DOL should respectfully consider claimants like myself, a high risk patient that does not have Medicare and needs access to E-visit coverage as a high risk patient. My physicians have recommended E-visits for me as they recognize my high risk status.

I would appreciate any assistance you can provide as I will need to cancel critical medical care, which is unacceptable, unless a provision is made to provide coverage for E-visits other than (HRHC) and (DME).

- Email from claimant in April, 2020.

A claimant's son, who served as his AR, contacted our office when his father's cancer treatment team and coordinated nursing team advised him to no longer have any outside medical or home health workers into his home as a result of the pandemic and his weakened immune system. The AR was aware of DEEOIC's conflict of interest policy prohibiting the same individual from serving as a claimant's AR and home health care aide. Under the circumstances, however, the AR wanted to know if an exemption could be granted for him in order to serve as the claimant's AR and home health aide and be

²¹ DEEOIC subsequently issued Bulletin No. 20-07 and Bulletin No. 21-03, which combined to extend Telemedicine for routine physician appointments through September 30, 2021.

compensated for his work providing home health care. This issue was referred to a DEEOIC medical benefits examiner for a determination. However, it highlights what our Office has discussed in previous years, which is that some people live in remote areas of the country, or live under circumstances where the only person in their home to assist them with their home health needs is also the only person available to serve as their AR. Thus, our recommendation is that in certain circumstances, DEEOIC should consider whether exemptions could be granted for claimant's who do not have access to a separate AR and home health care aide.

In another instance, a claimant contacted us after the issuance of Bulletin 20-03 which addressed telemedicine for home and residential health care and durable medical equipment, but before the issuance of Bulletin 20-04 which addressed telemedicine for routine physician appointments. This claimant needed to visit a doctor for treatment of his/her covered illness, yet because of the pandemic the physician was only seeing patients in person in emergency situations. The physician offered to see the patient via telemedicine. This claimant contacted our Office when DEEOIC refused to approve the telemedicine visit. A few weeks later DEEOIC issued Bulletin 20-04. Nevertheless, during that period before the issuance of Bulletin 20-04, when because of the pandemic many physicians were only seeing patients in emergency situations, claimants such as this one who needed to see his/her physician found themselves in a quandary.²² And in some instances, claimants were delayed in receiving their medical treatment.

B. Difficulties and Delays in Obtaining Medical Care and Prescription Medication

Some claimants have been eligible for medical benefits under the EEOICPA for an extended period of time, and one such claimant who was receiving specific medical benefits for over ten years contacted us for assistance in 2020 upon learning first, that his/her authorization for medical treatment was no longer being handled by his/her claims examiner, and second, after being informed that authorization for the specific medical care he/she had been receiving was now in question. The claimant's first reported concern was that he/she had not been informed that the claims examiner assigned to his/her claim, and for whom he/she had developed a strong working relationship, was no longer in charge of authorizing medical treatment. However, the claims examiner who had been authorizing claimant's medical treatment reportedly assured the claimant that simply because a medical benefits examiner (MBE) was now handling all medical benefits authorization requests did not mean that those requests would require anything new from the claimant. However, upon claimant's first conversation with the MBE,

²² And this quandary was made worse when the claimant was told, or was of the opinion, that he/she was required to use the EEOICP medical benefits card for all treatment related to the covered illness. Thus, some claimants felt that the only options available to them were: (1) forego seeing the doctor; or (2) paying out-of-pocket for the visit.

he/she was informed that reimbursement for travel to claimant's health care provider, who was multiple hours away from his/her home, was unlikely to be approved. Claimant was also informed that the medical visit itself would unlikely be covered. While attempting to obtain travel authorization from the MBE, the claimant purportedly found themselves within an hour of needing to give the medical provider notice of appointment cancellation before the MBE finally gave the claimant verbal approval for travel reimbursement for the trip. However, when claimant returned from the appointment and later checked the OWCP medical bill portal, the portal indicated approval was still pending. The claimant contacted his/her MBE again and was informed that his/her health care provider, whom he/she had been treating with and who had been receiving payments for medical services from DEEOIC for ten years, was no longer going to receive authorization for claimant's treatment. The claimant proceeded to have the primary physician overseeing his/her care write a letter to the MBE addressing the need for ongoing treatment and support services with the health care provider in question. After claimant submitted the letter to his/her MBE and did not receive a response, he/she contacted our Office for assistance, writing in part,

I don't want to continue this anxiety of not knowing if the medical support services that DOL has supported for many years will suddenly be found not medically necessary. My pulmonologist relayed to me through her medical assistant that she believes that the medication management and counseling are necessary for my well-being.

Nothing has changed. I still have chronic beryllium disease contacted [*sic*] from working at one or several DOE sites in this country...If anything, I need these services now more than I did 10 years ago since my body and mind are less able to function satisfactorily.

Based upon our experience, for claimants such as the one described above, to have the medical treatment they routinely received for a progressive illness called into question immediately or shortly after their claim is transferred to a new examiner can have a significant impact. First, as this claimant reported to us, is what felt like the arbitrary nature of his/her medical treatment being potentially denied, i.e., as a result of the replacement of the claims examiner with a MBE. Second, after the claimant's attempts to reach them by telephone, the lack of communication from the MBE and CE potentially delayed treatment and therefore generated anxiety.²³ And third, according to the claimant, "[MBE] said [their] supervisor did not want [them] to approve the mileage

²³ DEEOIC does not permit email communication between DEEOIC employees and claimants or anyone else outside of DEEOIC involved with claims. Thus, communication with DEEOIC representatives may only occur by telephone and written correspondence, the latter of which may be sent by mail, fax, or uploaded to through the Energy Document Portal (EDP).

reimbursement and that if they were audited, it was on [MBE] if they took a hit for having approved my trip.” Claimant relayed to us that this comment made them feel as if authorization for their medical benefits was being viewed through the lens of the potential impact it could have on the MBE’s job performance.

Claimants and home health care providers also contacted us seeking information and assistance in 2020 when they began experiencing delays in the authorization process for home health care benefits. Some of the delays described involved the initial authorization process for new services, and others involved the phase during which DEEOIC sometimes seeks clarification or additional evidence to make a determination regarding reauthorization of services. One provider complained that it was now typical for a renewal or increase in home health services request to take approximately three months to process, and questioned whether this was the new “normal” processing timeframe for DEEOIC. The provider concluded, “I realize that they changed systems and that a number of things are delayed due to COVID-19 but this seems like a really excessive amount of time regardless.” We were unable to identify the exact nature of the delay in this claim, but the provider informed us that the request was eventually approved.

In another instance, an AR called our Office regarding what they described as, “...problems acquiring and keeping home health care.” The AR complained of having difficulties with the level of care provided by some of claimant’s previous home health care providers, and wanted to know if there was a process by which he/she could have DEEOIC look into his/her concerns. The AR further inquired about the status of the request for HHC that had been submitted to DEEOIC and for which no response had been received for seven weeks. In response to our inquiry on this case, DEEOIC shared that the MBE was working with the claimant’s doctor and the claim would be handled expeditiously. However, one month later, claimant’s AR again contacted our office after being unable to determine the status of the HHC request. We have found that it can be challenging to determine exactly why some claimant’s claims for HHC take a significant period of time to move through the process. Based upon our communication with claimants and DEEOIC in 2020, sometimes the adjudication of these claims has been delayed without an explanation from DEEOIC, and in other cases, DEEOIC has been working “behind the scenes” to develop the claim but has not responded to claimant’s telephone calls, leaving the claimant feeling somewhat in the dark.

For claimants who need payment for prescription medication authorized by DEEOIC, the urgency of the authorization and/or approval process is generally heightened due to claimant’s immediate need for the medication, as well as the potential significant cost to claimant if payment for the medication is not approved by DEEOIC. The AR for a claimant who had been taking two prescription medications covered by DEEOIC contacted our Office when DEEOIC declined to approve one medication the claimant’s

doctor had prescribed in lieu of the original two. Claimant's AR reported to us that they were informed by DEEOIC that the single medication was not "an approved drug." It was unclear to the AR whether DEEOIC was suggesting the drug had not been approved by the FDA; or, that the drug was not normally used to treat the accepted illness; or, that the doctor had not explained why he changed the claimant's medication.

Another AR complained when the claimant's prescription medication for an accepted covered illness was denied, first for being dispensed in the wrong form, injectable instead of tablet; and then, for being prescribed for an "off label" use. In response, the AR submitted letters from the claimant's doctor to DEEOIC addressing the need for the medication to treat the accepted covered illness, as well as research articles supporting the use of the medication for the claimant's accepted illness. However, DEEOIC informed that AR that the OWCP Medical Director had reviewed the claim and had provided the basis for the denial of the medication. The AR specifically questioned our Office as to why the opinion of a referee specialist,²⁴ as described in the DEEOIC Procedure Manual, was not being sought by the MBE given that the claimant's physicians and the Medical Director were in disagreement regarding the prescribed medication. After also speaking with the MBE about a referee specialist, the AR was advised that three letters from the claimant's doctors, several research articles, and encounter notes were not sufficient to support authorization for the medication. The AR was then asked to submit the chart notes from the claimant's physician.

In a subsequent communication to our Office, the AR wrote,

I have already contacted the physician about the chart notes. The main problem is there is no report from [the Medical Director]. All I have is a vague paragraph from the CE that I have been told is from [the Medical Director]. That's what I mean about moving the goalposts, without [the Medical Director] detailing his objections I could be playing the wrong stadium, wrong city, or wrong state.

This claim exemplifies the confusion that some claimants and ARs encounter as they try to navigate something as seemingly straightforward as approval for medication. Here, the claimant's AR and physicians were fully capable of engaging DEEOIC on a high level with respect to providing medical evidence and scientific research to support the claim, and even had an understanding of the adjudication process as outlined in the

²⁴ A referee specialist opinion is considered necessary where the weight of medical evidence is equal between the opinion of the treating doctor and that of the CMC or Second Opinion physician. The CE obtains a Referee Specialist opinion by requesting a third, impartial physician review the competing opinions presented. The assigned physician then evaluates both sides of the competing argument, and makes the deciding conclusion. *See* EEOICP PM, Chapter 16.15 (September 14, 2020).

Procedure Manual. Nonetheless, the AR was confused by the reliance upon the Medical Director's opinion, particularly owing to the fact that MBE did not have a report from the Medical Director to share with the claimant or his/her physician. The AR complained to our Office that he/she was uncertain how to ask the claimant's physician to respond to the Medical Director's opinion when the report was unavailable. The full scope of the Medical Director's involvement in the adjudication of pending claims is unclear, and further clarification would be beneficial for the claimant community.

C. Difficulties with Expedited Adjudication and Medical Care

In their conversations with us, some claimants have mentioned that they were told by personnel associated with DEEOIC that once a claim is accepted, the claimant is required to use the DEEOIC medical benefits card when paying for medical services and treatment related to their covered condition. In fact, a few claimants were a little shaken when personnel associated with DEEOIC warned them that once they received their EEOICP medical benefits card, it was against the law to use their private insurance or Medicare to pay for treatment or services related to the covered condition.²⁵ In response to such statements, some claimants have expressed concern that if they are to use this card for treatment and services related to their covered condition, then DEEOIC needs to ensure that the personnel and procedures are in place to facilitate the use of this card. And in this regard, some claimants have questioned if DEEOIC has the personnel and procedures in place to address emergency situations.

The EEOICP Procedure Manual specifically addresses the process for requesting emergency authorization to receive home and residential health care, *see* Federal (EEOICPA) Procedure Manual (PM) Chapter 30.11, Version 4.3 (September 14, 2020) and has procedures for the priority processing of claims for claimants who are end-stage terminally ill. *See* Federal (EEOICPA) PM Chapter 11.8, Version 4.3 (September 14, 2020). Yet, in spite of these procedures, we were contacted by claimants and their representatives who complained of difficulties receiving authorization for medical treatment or priority processing of their claim when time was of the essence.

One such instance arose when a claimant in a hospital in one state needed authorization to be transported to a hospital in another state within a short period of time. Because of the need for a quick response, after submitting the written request, the claimant followed up with a telephone call to DEEOIC. Claimant contacted our Office when his/her efforts to talk to DEEOIC were unsuccessful. We immediately forwarded this concern to DEEOIC. Four days later the patient coordinator at the hospital the claimant was being

²⁵ Some claimants found this statement disconcerting because they were aware of instances where when a bill submitted to DEEOIC had not been promptly paid, some providers had taken it on their own to submit the bill to Medicare or the claimant's other medical insurance provider.

transported from called our Office and reported that because of the need for an ID and password to access the EEOICP online portal, their counterpart at the other hospital could not access the portal to obtain the authorization letter. The patient coordinator also expressed his/her concern that if the matter was not resolved quickly, the claimant might lose the down payment made to secure their transport between hospitals. This patient coordinator again called one hour later when no one from DEEOIC was available to speak with him/her, and no one from DEEOIC had contacted the patient coordinator. When we followed up, the patient coordinator confirmed that he/she had talked to DEEOIC, and that the other hospital was still requesting pre-authorization, or a document stating that pre-authorization was not necessary for the actual hospital to hospital transfer. Minutes after we relayed this information to DEEOIC, we were advised that DEEOIC had contacted both hospitals and had left a direct telephone number for these institutions to call.

Similarly, even though DEEOIC has procedures for expediting claims of end-stage terminally ill claimants, family members complained of not knowing how to contact DEEOIC, especially during non-business hours, to ask questions about this procedure and/or to initiate this process.²⁶ When a claimant's condition took a sudden turn for the worse, some families found it frustrating, to say the least, to have to wait until normal business hours to contact DEEOIC.

According to the DEEOIC Procedure Manual, claims examiners and hearing representatives are instructed to watch for indicators of an end-stage terminally ill claimant any time they are reviewing a case file or preparing a decision. Indicators of end-stage terminally ill claimants include requests for hospice care, medical evidence stating that the claimant is at the end-stage of an illness, or telephone calls or letters from Resource Centers, congressional offices, ARs, family members, or medical providers regarding the claimant's illness. Upon receipt of information that an employee may be at a terminal stage of an illness, the claims examiner must coordinate notification of the situation to the District Director, Assistant District Director or FAB Manager. The District Director, Assistant District Director or FAB Manager must use sound judgment in determining if priority handling needs to occur. If medical documents or other information indicate that the claimant is in the end-stage of his/her illness or that death is imminent, the District Director, Assistant District Director, or FAB Manager directs case action to occur in an expedited manner and ECS is updated to include the terminal indicator. Priority handling for terminally ill claimants requires all DEEOIC staff to

²⁶ We encountered family members who only became involved with the EEOICPA claim when the claimant became incapacitated. These family members oftentimes knew very little, if anything, about this program. As such, in our opinion, it is unreasonable to expect these family members to know about, or know they could go to the Federal (EEOICPA) Procedure Manual for guidance.

undertake claim adjudication activities in an expedited manner, wherever possible. *See* EEOICP PM, Chapter 11.8(a) (September 14, 2020).

Following the submission of hospice medical records to DEEOIC for a claimant with brain cancer, an AR was informed by a District Director that, “The doctor also says he will need 24 hour care over the next several days to weeks, but doesn’t provide a timeframe or state that the patient is at the end stage of his illness. Is it possible to have the doctor be a little more specific regarding his opinion of end stage?” In response to this request for additional medical evidence, the AR expressed frustration that DEEOIC seemed to have shifted to requiring the treating physician literally use the words “imminent death” or “end-stage” before DEEOIC would designate the claim as terminal. The AR stated this requirement was not supported by the DEEOIC regulations or policy. Furthermore, the AR explained that while the 75 page discharge order from the hospital to hospice care did not use the words “imminent death” or provide an exact prognosis, hospice generally requires a prognosis of six months or less to live. We have observed that this complaint has become more frequent, and for those families who do not have an AR, responding to DEEOIC’s requests for more specific evidence regarding when claimant will be at the end-stage of their life can be unbearable. Unfortunately, for those who cannot get the claimant’s doctor to make such a specific prognosis, in addition to the loss of their loved one is the potential loss of some of the benefits the claimant may have been eligible to receive.

Chapter 4 – Difficulties Understanding the EEOICPA Claims Process

The vast majority of our contacts in 2020 were from individuals who contacted our Office via mail, telephone, or email. Most of these individuals contacted us with questions or requests for assistance concerning an ongoing claim or a claim that had been denied. And whether it was claimants who were in the midst of processing a claim, or claimants who had already received a decision, our interactions showed that some claimants struggle to understand what is required of them in processing a claim under the EEOICPA.

As in previous years, when claimants approached us with their complaints, grievances, and/or requests for assistance, it oftentimes did not take long to recognize that many claimants did not fully understand the EEOICPA and/or the EEOICPA claims process. This lack of understanding became apparent when claimants were unable to explain what had transpired with their claim, or could not clearly articulate the concerns that prompted them to contact us. For instance, it was common to encounter claimants who assured us that they had received a decision from EEOICPA, but could not tell us if the decision they received was a recommended or final decision. In fact, we frequently found that some claimants did not understand the difference between a recommended and final decision. This lack of a full understanding of the EEOICPA and/or the EEOICPA claims process can have a profound impact on a claimant's ability to prove their claim. For instance, it often impacts a claimant's ability: (1) to understand the stage of the claims process their case is in; (2) to develop evidence in support of their claim; (3) to comprehend the documents and decisions received from DEEOIC; and/or (4) to know how to respond to these documents and decisions.

What follows are just a few examples of instances where the claimant's lack of a full understanding of the EEOICPA and/or the EEOICPA claims process had an impact on his/her ability to pursue a claim.

- Some years ago, a claimant underwent a medical screening sponsored by the Former Worker Medical Screening Program and was diagnosed with an illness. In 2020, this claimant attended the JOTG outreach event held in Santa Fe, New Mexico. Nevertheless, when this claimant contacted us after attending the Santa Fe event, he/she wanted to know what to do next. When we determined the claimant had never filed a claim, we referred him/her to one of the Resource Centers to file a claim for benefits.
- In inquiring about the status of his/her claim, the claimant's statement that the claim was "at the end" was just one of the statements that revealed that this claimant thought his/her claim was nearing the end of the adjudication process. In response to our inquiry to DEEOIC, however, we discovered that a recommended decision had not yet been issued. In our subsequent conversation, we provided this claimant with a thorough overview of the EEOICPA claims process.

- In a couple of instances this year claimants approached us to complain they had not received the additional money to which they were entitled. Additional questioning was needed in order to determine these were Part E claimants who were seeking additional impairment compensation. In some instances, these claimants did not realize, or forgot, they could apply for additional impairment compensation every two years. In other instances, while they vaguely knew there were eligible for additional compensation, the claimant did not understand the program well enough to articulate what they were seeking.

A claimant's lack of understanding of the claims process can likewise impact a claimant's ability to seek reconsideration or reopening of a previously denied claim. In contacting us, most claimants were not seeking to simply overturn an unfavorable decision – they often wanted a better understanding of the decision or had unanswered questions. And in most cases, to assist these claimants we provided a thorough explanation of the denial and/or advice on developing additional evidence.

In fact, in a small percentage of these cases, we uncovered a specific issue that we felt claimants should bring to DEEOIC's attention. The following cases are illustrative of this scenario.

- A claimant reached out to our Office for assistance following a JOTG outreach event. The claimant asked us for help understanding why his/her cancer claim did not meet the Special Exposure Cohort criteria. Our subsequent review of the claim file permitted us to provide the claimant a better understanding of the denial, as well as inform the claimant that when the claim was referred to NIOSH for a radiation dose reconstruction, all of the diagnosed cancers had not been reported to NIOSH. In addition, the most recent impairment decision did not appear to address the claimant's accepted skin cancers. We suggested this claimant seek reopening of the claim based upon this finding that all diagnosed cancers may not have been included in the NIOSH dose reconstruction, and explained the process for doing so. We also suggested the claimant confirm with DEEOIC that all accepted cancers under Part E had been included in the impairment evaluation.
- A claimant contacted us to complain about the denial of his claim for prostate cancer. However, in speaking with the claimant we discovered that he had been diagnosed with skin cancers for which he had never filed a claim under the EEOICPA.²⁷ We then referred the claimant to one of the Resource Centers to file a claim for benefits for the skin cancers.
- The claimant was issued a Final Decision that found the dates of covered employment were April 1976 to March 1989. However, in the Statement of Accepted Facts sent to the Industrial Hygienist (IH) and the Contract Medical Consultant (CMC), DEEOIC reported the claimant's date of covered employment were April 1976 to November 1978. We provided

²⁷ It is common to encounter claimants who are not aware that they can file new claims when additional illnesses arise. We see this most frequently with skin cancer. Claimants do not realize that after a claim for skin cancer is denied, should they be diagnosed with new skin cancers, they can and should file a new claim.

claimant an explanation of the possible impact this discrepancy could have with respect to his/her claim, and also explained the process for requesting reopening of the claim.

- In two separate cases, claimants received decisions denying their claims wherein the decisions stated the claimants had worn personal protective equipment (PPE) while performing their job duties. Both claimants insisted this was not true, and that they had not worn PPE as stated in the decisions. Upon our Office's review of the claimants' Occupational History Questionnaires, when asked if they wore PPE, both claimants had answered "never/infrequent." We provided claimants an explanation of the possible impact this discrepancy could have with respect to their claims, and also explained the process for requesting reopening of the claims.
- A claimant with a newly accepted claim for esophageal cancer received his/her medical benefits card and contacted us with questions and seeking information regarding how to use the card. In this conversation, we discovered that the claimant was not aware that in order to have DEEOIC pay for medical conditions resulting from the accepted illness, he/she first had to file a claim for a consequential condition.²⁸ Claimants in this scenario often question why there were not informed that they could file a claim for a consequential condition when they received the final decision accepting their original illness. Upon being informed of their ability to file a claim for a consequential condition, claimants invariably ask our Office whether there is a separate claim form for filing a consequential illness claim, to which we inform them that they use the same claim form (Form EE-1) they used to file their original claim for benefits, but must write in on the claim form that they are filing for a "consequential illness."

On many occasions, individuals who meet or speak with us about the status of their claim, or who seek to better understand what they can expect to happen in the next phase of their case, contact our Office again when they have additional questions, concerns or complaints. We first met one such individual who was serving as a survivor's AR (and daughter) at an AR Workshop in 2019. While the survivor's claim had been previously denied, the AR attended the workshop in order to gain a better understanding of the EEOICPA, and to see if anything could be done to change the outcome of the claim. The conversation with the AR at the workshop revolved around the basic elements necessary for a survivor to prove their claim under the EEOICPA. However, when the AR contacted us in 2020, he/she shared their frustration with not being provided a better understanding of the EEOICPA prior to the claim being denied. The AR wrote,

I sent a letter to the Claims Examiner expressing my concerns about the many years that have passed by and if I had known about what records I needed to obtain to support this claim I would have sought them without a doubt. But, now

²⁸ This is a common misconception that we encounter. After their claim is accepted, claimants often assume that they can use the medical benefits card for everything related to the accepted illness. Thus, claimants pay out-of-pocket for consequential conditions expecting to be reimbursed. Instead, they discover they first need to file a claim and have the consequential condition accepted by DEEOIC.

I believe there has been a huge disconnect on how the same Claims Examiner has denied all of my claims. I'm concerned that my claim has not been properly processed. I would admit, if I had just been aware of more medical records, I mean the many records I could have had the opportunity to get those, but I don't think I had a Claims Examiner that didn't take the time to help assist me through this process. I know if she had just told me like your agency explained to me at the DO[L] workshop, I may have a more favorable outcome.

This case not only exemplifies the ongoing need for DEEOIC to communicate, in a practical way, the ways in which claimants can obtain evidence to support their claim, but also the need to inform claimants and ARs how the claims process works and what they can expect to happen at each stage of the adjudication process.

Some individuals who contact our office seeking information also raise issues regarding the claims process that are new to us. In 2020, a question was posed to our Office by an AR regarding the meaning of the term "frozen universe" that was used by a claims examiner to describe the status of a claim. The AR explained that the case had been pending for a long time, and that when the AR inquired about the case status, the CE advised that the case was in the frozen universe status, which meant the completion date for the case was now pushed to the end of the fiscal year. The AR contacted us seeking more information about "frozen universe" cases, and expressed concern with the adjudication of cases being delayed without notice to the claimant. We were unfamiliar with the term, and in searching DEEOIC regulations and policy found no mention of it. In response to our inquiry, DEEOIC stated that the claim in question was being actively adjudicated, and "With regard to 'Frozen Universe' cases – in general, this term refers to cases that are pending from a prior fiscal year. Although this case is part of the 'frozen' workload, as noted above, a recommended decision is forthcoming, and the case will then proceed to the Final Adjudication Branch." It remains unclear the impact such a designation has on claims, and we are hopeful DEEOIC will disclose more information regarding the term and what it means for claims that fall under the designation.

Finally, in the 2019 Annual Report to Congress, we discussed the importance of claimants being made aware that they could request a copy of their claim file in order to understand what information DEEOIC has, or does not have, in their claim file.²⁹ *See* 2019 Annual Report to Congress, Recommendation No. 5, page 72 (July 28, 2020). A claimant who contacted us for assistance with his/her claim for COPD had already been issued a Recommended Decision to deny his/her claim when we first spoke. The claimant provided our Office with a copy of the Recommended Decision and the expert opinion reports obtained by DEEOIC to support the decision. The claimant further explained that he/she believed there were errors in the expert's reports. In discussing the claimant's concerns, the claimant was frustrated when first informed by our Office, that he/she could have requested a copy of his/her entire claim file. Claimant

²⁹ The 2018 Annual Report to Congress also made the same recommendation for claimants to be informed that they have the right to request a copy of their claim file. *See* 2018 Annual Report to Congress, Recommendation No. 6, page 56 (July 30, 2019).

would have appreciated the opportunity to review the evidence the experts relied upon to make their determinations before the recommended decision was issued to deny their claim. The claimant indicated he/she would request a copy of his/her entire claim file from DEEOIC immediately.³⁰

³⁰ Any claimant who wishes to obtain a copy of their claim file may do so, but the request must be made in writing to DEEOIC. Furthermore, if they have a preference, the claimant should specifically state whether they wish to have a paper copy of the file, or a copy of the file on a compact disc (CD).

Chapter 5 – Issues Related to Impairment Claims

In previous Annual Reports to Congress, complaints regarding claims for impairment benefits have largely been due to: a) claimants' lack of awareness that they must file a claim form each time they wish to claim impairment benefits; b) difficulties claimants encountered attempting to find a qualified physician to perform their impairment evaluation; or c) claimants' lack of awareness that they could file for increased impairment benefits every two years.

By way of background, under Part E of the EEOICPA, once a claimant's accepted covered illness has reached maximum medical improvement, they may file a claim for impairment benefits. The impairment evaluation must be performed by a qualified physician, and must include the percentage of whole person impairment for each accepted covered illness. The compensation payment is calculated by multiplying \$2,500 by each percentage of whole-person impairment. A claimant may file a claim for increased impairment compensation every two years, and benefits are payable only if the impairment evaluation concludes that the covered illness has worsened, as expressed by an increased impairment rating. There are exceptions to the two-year waiting period, and a complaint brought to us by an AR in 2020 highlights the challenges claimants and ARs sometimes face navigating DEEOIC's rules regarding these exceptions.

DEEOIC has published policy guidance regarding when a CE may waive the two-year waiting period. According to the Procedure Manual, the CE may consider waivers under the following circumstances.

- (i) The CE accepts a new covered illness since a previous Final Decision awarding impairment and the condition relates to an organ system (in accordance with the AMA's Guides to the Evaluation of Permanent Impairment, 5th Edition) that was not included in a prior rating.
- (ii) The claimant requests a waiver of the two-year rule and submits medical evidence, documenting since the last impairment rating, that the accepted condition(s) has caused a substantial detrimental effect to the claimant's living circumstances, one or more Activities of Daily Living (ADL), or medical status. The effect should represent a change unlikely to improve.
See Federal (EEOICPA) Procedure Manual, Chapter 21.16(a)(1), Version 4.3 (September 14, 2020).

In the complaint filed with our Office, the claimant's claims for COPD and asthma were accepted in 2019. Claimant subsequently received an impairment award for COPD, and then a Recommended Decision to award additional impairment compensation for asthma. However, the FAB remanded the Recommended Decision for the asthma impairment to the district office for administrative closure. In a follow-up letter to the claimant, the CE explained that the

claimant was ineligible for impairment benefits for asthma because COPD and asthma were both pulmonary conditions, which are part of the same body system, and therefore were both covered by the impairment evaluation for COPD. However, in the same letter, the CE acknowledged receiving letters from claimant's pulmonary doctors stating claimant had significant decrease in pulmonary function testing, decrease in exercise capacity, and an increase in dyspnea (shortness of breath) subsequent to the COPD impairment evaluation. Thus, instead of treating the doctor's letters describing the worsening of the claimant's pulmonary conditions as a request for the waiver of the two-year waiting period, DEEOIC administratively closed the impairment claim and at the same time invited the claimant to file a new claim for impairment along with a request for a waiver of the two-year waiting period. The AR found this guidance confusing and inefficient, and contacted the CE for additional information. The AR reported being further confused after he/she was informed by the CE that the only circumstances under which the two-year waiting period could be waived was if the claimant were terminally ill. Because the claimant was not terminally ill, the AR was informed that the claimant would have to pay for their own evaluation.

The AR contacted our Office to complain of what they characterized as confusing communications from DEEOIC. The AR pointed out the apparent discrepancy between the Final Decision remanding the claim for administrative closure; the letter from the CE informing the claimant he/she could file a new impairment claim along with a request for the two-year waiting period to be waived; and, the conversation with the CE wherein the AR was informed that the only circumstances under which the two-year waiting period could be waived was if the claimant were terminally ill.³¹ The AR believed that the letters from the claimant's treating physicians substantiated the decline in the claimant's pulmonary conditions such that the two-year waiver should have been granted and the claimant awarded the compensation recommended in the Recommended Decision. The AR also could not find any policy guidance indicating a claimant must be terminally ill in order to be granted an exception to the two-year waiting period. Our review of the documentation provided by the AR suggests that claimants would benefit from clearer guidance for DEEOIC staff regarding the waiver of the two-year period for additional impairment benefits, as well as under what circumstances impairment claims should be administratively closed.

Also in 2020, a new subset of complaints regarding impairment evaluations were brought to our attention by ARs and a physician who performed impairment evaluations for claimants. We were first contacted in September 2020 by an AR who wrote to us regarding impairment

³¹ The EEOICP Procedure Manual does not limit the filing for an exception to the two-year waiting period to claimant's who are terminally ill. *See* Federal (EEOICP) Procedure Manual, Chapter 21 (September 14, 2020).

evaluation reports that had been rejected by DEEOIC after the OWCP Medical Director became involved in the claims.³² According to the AR,

What we are seeing is that when [the rating physician] writes an impairment review, they are almost always being sent to the ‘National Office’ for review by the DEEOIC Medical Director Dr. Armstrong who always states the Impairment wasn’t conducted in accordance with the 5th Edition AMA guidelines. This happens virtually every time [the rating physician’s] report his [sic] Dr. Armstrong’s desk.

Dr. Armstrong or the CE sends it back and [the rating physician] is forced to write an amended review which takes substantial time on his part and he always is careful to refute Dr. Armstrong’s claims line by line. The responses seem logical and well written to me; however, I’m not a physician.

DOL Claims examiner’s then completely ignore [the rating physician’s] response because it disagrees with and does not fall in line with Dr. Armstrong’s suggested impairment rating. Thus, they consider it ‘a tie’ and they need a ‘tie breaker.’

The report is then sent to a CMC for review, who never conducts a full impairment rating and interviews the client about their activities of daily living etc. They simply fall lock-step with Dr. Armstrong and give the exact replica of his Impairment suggestion. Thus, the client is truly never given even a shot at an impartial/independent Impairment process and their rights are being circumvented...

- September 17, 2020 email to the Office of the Ombudsman.

The AR shared with us the reports from the rating physician, as well as the referral to the CMC and the CMC report itself. The referral to the CMC stated that Dr. Armstrong had provided a July 2, 2020 report to the district office. Furthermore, the CMC report stated that Dr. Armstrong’s July 2020 report, as well as a separate memo from Dr. Armstrong, were reviewed by the CMC when drafting their impairment evaluation. Ultimately, the CMC agreed with Dr. Armstrong’s findings. A Recommended Decision was then issued which stated that the Medical Director had reviewed the rating physician’s report and found it, “...was not performed in accordance with the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. The District Office was instructed to refer your case to a Contract Medical Consultant (CMC) for an impairment evaluation.” The district office accepted the CMC report over the rating physician’s

³² The role of the OWCP Medical Director as outlined in the DEEOIC Procedure Manual is discussed in Chapter 3(b) of this report.

reports and awarded claimant \$22,500 impairment compensation. Had the amended report of the rating physician been accepted, claimant's impairment award would have been \$190,000.

The rating physician in the above-referenced case also wrote to our Office in October 2020, outlining his/her concerns regarding a) the process by which his impairment evaluations were all seemingly being diverted to the Medical Director for scrutiny and oftentimes, rejected; b) his/her inability to obtain an explanation from the Medical Director as to how his/her impairment evaluation reports were not performed in accordance with the AMA Guides; and, c) significant delays in receiving payment for his/her impairment evaluation reports. The physician specifically stated that from 2008 through approximately March 2020, only a handful of his/her impairment evaluation reports generated a request for clarification from the district office, which he/she provided and the impairment claim was then processed. However, as of February 2020, no payments for impairment evaluation reports had been received for several months despite the fact that the reports were being submitted weekly. According to the physician, it reached the point where payment for approximately 100 reports were delinquent, and DEEOIC, as well as the new medical bill contractor were allegedly unable to assist in getting the outstanding bills resolved. However, the physician commended the Hanford Resource Center for finally assisting with the resolution of a number of the unpaid bills. As of October 2020, the physician reported that payment for approximately twenty reports from February to May 2020 remained delinquent.

Finally, in November 2020, an AR forwarded to our Office a copy of their public comments to the Advisory Board on Toxic Substances and Worker Health (ABTSWH) for the meeting held on November 5-6, 2020.³³ The comments on the Medical Director's involvement in the adjudication of impairment claims raised issues and complaints similar to what had already been reported to our Office. First, the AR complained that the Medical Director was inserting himself into the claims adjudication process by writing medical opinions that became part of the claims process despite this role not being explicitly mentioned in the EEOICP Procedure Manual. Second, the AR complained that because the Medical Director conducts audits of the CMC reports on behalf of DEEOIC, when a CMC is requested to provide an opinion for an impairment claim and sees the opinion of the OWCP Medical Director in evidence, the CMC is improperly influenced to agree with the Medical Director. And third, the AR complained that when impairment claims are sent to the Medical Director at National Office, there is no timeline by which the Medical Director is to review the claims. Therefore, some claims have been delayed in excess of five months while the Medical Director reviews them.

Our office does not have medical experts on staff to review the substantive medical complaints raised by the rating physician and ARs. However, as it relates to the role of the Medical Director in the adjudication of impairment claims, we are concerned if claimants and/or their ARs are not

³³ The comments to the ABTSWH are posted in full on the ABTSWH website. The website for the ABTSWH can be accessed via the DEEOIC homepage, or directly at <https://www.dol.gov/agencies/owcp/about/AdvisoryBoard>.

being provided copies of the reports written by the Medical Director as part of the claims adjudication process. Absent the ability to read and potentially rebut the opinion of the Medical Director, claimants appear to be at a disadvantage as they seek to rebut the findings. Likewise, we are uncertain as to whether DEEOIC has provided notice to claimants and/or their ARs that their impairment claim has been sent to the National Office for review by the Medical Director. As we have suggested in previous Annual Reports to Congress, when claims are sent to the National Office for review, claimants should be informed and provided an expectation of how long their claim will be there, particularly if there is no regulation or policy providing a timeline for such reviews.

Chapter 6 – Customer Service, Delays, and Other Administrative Issues

A. Communication Issues

A frequent complaint involves communication issues, particularly difficulties claimants, ARs, and even health care providers have connecting and speaking with DEEOIC personnel by telephone. Those they wish to speak with range from Resource Center staff to claims examiners, hearing representatives, medical benefits examiners, and medical billing contractor staff.

Until 2019, those who wished to speak with DEEOIC personnel would call the office of the person they wished to speak to directly. However, in 2019, DEEOIC policy changed such that all incoming calls are now answered by one of the eleven (11) Resource Centers.³⁴ The stated reason for the change was, “...in order to focus on and improve customer service.” *See* DEEOIC Response to 2019 Annual Report to Congress, page 5 (January 15, 2021). DEEOIC further stated that this would result in an increase in the number of calls answered by a live representative, efficiency in answering basic questions, and decreased hold times. (*Ibid.*). Questions and comments could also be submitted to DEEOIC through the public email address, the customer satisfaction survey, or by letter. (*Ibid.*).

It is our understanding that as calls come into the RC, the RC staff are to assist callers to the extent that they can. When the call is for someone in the district office, FAB, or medical benefits unit, the RC is to transfer the call to the appropriate person in those offices. In 2020, some of the claimants who contacted our Office were not fully aware of or did not understand that when they called the telephone number for what they had previously understood to be the district office or FAB, their calls were now being answered by the RC; and they did not appreciate that the RC staff who were answering their claims-related questions were not the claims examiners or hearing representatives who they previously spoke with when they called those telephone numbers.

In fact, some claimants were still adapting to the addition of medical benefits examiners into the mix of people who played a direct role in making decisions regarding their claims. Thus, during 2020, one of the hurdles claimants faced when calling DEEOIC was understanding who they were speaking to; what office that person was in; and what role that person played in their claim. And for those claimants who preferred to communicate by email, this was not an alternative because DEEOIC does not communicate with claimants or other stakeholders via email.

³⁴ The eleven Resource Centers are located in: Oak Ridge, TN; Portsmouth, OH; Amherst, NY; Denver, CO; Idaho Falls, ID; Paducah, KY; Las Vegas, NV; Espanola, NM; North Augusta, SC; Hanford, WA; and Dublin, CA.

For claimants who knew the names of their claims examiner or medical benefits examiner, it was apparent when listening to their problems that they were sometimes still confused as to which one was working on the various components of their claim. This confusion could be compounded when the claimant had, for example, a medical billing issue that drew staff from the medical billing contractor (Conduent or CNSI) into the equation along with the medical benefits examiner and possibly the claims examiner. So for a claimant with a number of ongoing claims, it has been reported that it is frustrating to receive a letter or communication from someone within DEEOIC who they are unfamiliar with, and for whom they have no history of working with.³⁵ Moreover, without the ability to have any communication between claimants and DEEOIC staff memorialized in emails, the claimant cannot rely upon a written history of communication between themselves and the CE/MBE in order to keep track of who they spoke to and what they spoke about. Claimants may send correspondence to DEEOIC, but we have found that few take the time to send their examiner a letter seeking the status of their claim, or to find out when a decision will be issued in their case.

Context is also relevant to the discussion of communication problems claimants reported to our Office in 2020 because most of the complaints we received were from claimants or ARs under a deadline to either provide information or evidence to DEEOIC; or to avoid having an unpaid medical bill go to collection; or to obtain benefits for a claimant who was near the end of their life. A typical request to provide medical evidence, employment evidence, and/or toxic exposure evidence from DEEOIC informs claimants to submit the requested evidence within 30 calendar days from the date of the letter. The 30 day deadline typically generates concern for most claimants because they know it can sometimes take longer than 30 days to get an appointment with their doctor, much less schedule an appointment to meet with and obtain a medical report from their doctor; or to simply obtain medical records from their doctor's office.³⁶ And while claimants are permitted to submit a written request for an extension of time, claimants were not informed that they may do so in the letters they received from DEEOIC requesting evidence and setting deadlines to submit evidence.

Many of these claimants or ARs then attempt to speak with their claims examiner or medical benefits examiner about the request(s) for evidence they received, and have reported that they often have to leave a voicemail message at the Resource Center or for their CE/MBE. We also received reports from claimants of the Resource Center not

³⁵ A claimant could simultaneously have claims for a new medical illness, impairment for an accepted covered illness, home health care benefits, and durable medical equipment, among other available benefits, all pending before DEEOIC at that same time. In this circumstance, claimant would minimally be working with a CE and MBE.

³⁶ DEEOIC usually sends claimants two letters seeking evidence, each giving claimant 30 days to provide the evidence. However, when claimant receives the first letter, they are often unaware that they will be afforded another 30 days to collect and submit their evidence.

attempting to directly connect the claimant with their claims examiner, but instead entering a message into the Energy Compensation System (ECS) for their claims examiner to give them a call. Regardless, at the point by which claimants typically contacted our Office to share their complaint and seek assistance, they were frustrated by the lack of communication, or the lack of timely communication. The lack of a response also did not help claimants feel any less concern or anxious about the primary problem or question they were seeking to speak with their CE/MBE about in the first place.

According to DEEOIC, in fiscal 2019, the District Offices completed 96.44 percent of return calls in one work day and 99.12 within two work days. The FAB returned 92.04 percent of return calls in one work day and 97.47 within two work days. Based upon the complaints brought to our attention in 2020, it is unclear if a call is considered “returned” when the CE/MBE returns a call and leaves a message for the caller, or when the CE/MBE actually connects with the caller and speaks to them regarding the purpose of their call. It was explained to our Office by claimants and ARs that they felt frustrated when they missed a call from DEEOIC because they believed they would then have to call back, leave another message, and then wait another day or two before their call would be returned. And for claimants and ARs working under a 30 day deadline, this meant it could take two days, four days, or sometimes longer just to speak with their CE/MBE before they could proceed with working on their claim.

At an outreach event in Santa Fe, NM in 2020, a DEEOIC representative shared during a medical benefits session that the Resource Centers had 60 people answering telephone calls.³⁷ Thus, it was our understanding that approximately 60 people were answering the calls for the 11 resource centers, four district offices, five FAB offices, and the offices of the medical benefits examiners. On average, then, each Resource Center had approximately 5.5 people to answer all incoming calls. According to DEEOIC,

In fiscal year 2019 the resource centers responded to 56,317 phone calls, conducted 3,971 occupational history interviews, performed 125,247 follow-up actions with claimants, and received 8,481 claims. The resource center staff provided exhibits and presentations at community health fairs, union meetings, Chambers of Commerce offices, Meals-on-Wheels sites, retiree and safety meetings associated with covered facilities, and Hazardous Waste Operations training sessions, which resulted in an additional 104,267 contacts and 4,620 claims.

³⁷ DEEOIC’s January 15, 2021 Response to the 2019 Annual Report to Congress indicated that in fiscal year 2019, 61 contract employees worked at the Resource Centers. *See* DEEOIC Response to 2019 Annual Report to Congress, page 3. (January 15, 2021).

*See DEEOIC Response to 2019 Annual Report to Congress, page 3.
(January 15, 2021).*³⁸

From the perspective of those who contacted us complaining of communication problems, specifically difficulties with being able to speak with their CE and/or MBE, perhaps it would be helpful to have more individuals available to answer incoming calls.

Moreover, while our Office endeavored to assist those who contacted us to complain regarding communication problems with DEEOIC, when asked whether DEEOIC had a dedicated person or office where they could file a complaint, we were only able to suggest they call and ask to speak with the supervisor of the person they wished to file a complaint or concern about. It is our understanding that claimants can either bring their complaint to a staff member's supervisor, or email the DEEOIC public email address regarding customer service problems. As we have written about in previous Annual Reports to Congress, claimants were reluctant to do so for fear of getting on the bad side of the person they complained about, who was also tasked with determining whether they would qualify for benefits.

Below is a brief summary of some of the complaints brought to our attention in 2020 involving communication issues.

- January 2020 – claimant “upset” that he/she cannot get through to anyone at DEEOIC.
- January 2020 – family member unable to get return call regarding outstanding medical expenses for claimant.
- March 2020 – CE not returning claimant's calls.
- April 2020 – AR trying to get information for a terminally ill claimant, complaining that it took 4 days for DEEOIC to return the call.
- May 2020 – MBE not returning calls to claimant with multiple treatment needs.
- June 2020 – Calls from AR not returned by district office as he/she attempts to assist terminal claimant.
- Provider sent a letter to DEEOIC addressing a matter and requested a follow-up telephone call. The provider contacted our Office because they had not received a response and did not know how to contact the responsible person at DEEOIC via telephone.
- July 2020 – Claimant complained of playing telephone tag with DEEOIC.
- July 2020 – Health care provider unable to get return call or assistance from DEEOIC.

³⁸ Additional Resource Center duties are further discussed in DEEOIC's Response to the 2019 Annual Report to Congress.

- August 2020 – Claimant told he/she would get return call to assist with online portal and their calls were not returned.
- August 2020 – Claimant expressed frustration because “people” keep saying they are going to call, and then do not call. Claimant further noted that the people who answered the number given to him/her by DEEOIC were not able to assist him/her.
- August 2020 – Claimant complained that it took 3 weeks to get a return call from DEEOIC.
- September 2020 – MBE not returning calls regarding payment for claimant’s home modification.
- September 2020 – “We have had to submit this DME request numerous times prior to this last submission. We were told that the [claimant] should contact DOL [MBE] regarding this matter, however, [MBE] does not return calls with the exception of twice when we asked the Cleveland DOL office to put us in touch with a supervisor.”
- October 2020 – claimant’s repeated calls not returned.

Based upon the complaints in 2020, it is clear that more focus will be needed in 2021 to determine what is really happening when claimants try to contact and connect with DEEOIC personnel. Are there sufficient staff to answer the calls for all those who wish to communicate with DEEOIC regarding claims? Are callers informed of the roles and possible limitations of those they are speaking with at DEEOIC? If so, when are they informed? Is DEEOIC providing an overview of the various people with differing job titles who will be handling their claims for benefits? Can more be done to monitor telephone calls between callers and DEEOIC staff? When is a call considered “returned” for purposes of DEEOIC tracking rates of responsiveness to messages left for RC and DEEOIC staff? Why aren’t claimants and others who contact DEEOIC provided a dedicated contact to file their complaint with, and from whom they can expect a response?

B. Delays

In 2020, it was not unusual for complaints regarding delays to overlap with the communication issues discussed in the preceding section, specifically where the communication issues resulted in what claimants believed were delays in their ability to meet DEEOIC deadlines. A novel set of complaints regarding delays were presented in 2020 as a result of the COVID-19 pandemic. Some of the issues originated with outside agencies, such as DOE and SSA, experiencing delays in obtaining and providing information to DEEOIC in order to process claims. Compounding these delays was what appears to have been a lack of notice from DEEOIC to claimants and ARs that the delays were occurring and potentially impacting the claims process.

For example, in August 2020, the DOE Office of Environment, Health, Safety and Security, which supports the EEOICPA, reported at the Teleconference Meeting of the

Advisory Board on Radiation and Worker Health that DOE EEOICPA Operations had been significantly impacted by the COVID-19 pandemic since mid-March.³⁹ DOE stated that it had been doing everything it could to respond to both individual records requests and records search projects, but acknowledged backlogs at many DOE sites. DEEOIC makes these individual records requests to DOE in order to verify claimed employment at DOE sites, among other things. DOE also stated it would do everything it could to complete all requests once sites had their staffing levels return to normal. In December 2020, DOE reported to the Advisory Board on Radiation and Worker Health that many DOE sites eliminated backlogs in the late summer or early fall, but some sites had returned to maximum telework in light of the rising infection numbers in their area. While DOE's Office of Environment, Health, Safety and Security did not have direct input into these decisions by DOE sites to return to maximum telework, DOE kept the advisory board updated on the status of its difficulties providing records to DEEOIC and NIOSH.⁴⁰

It is unclear if DEEOIC provided notice or information directly to claimants and their ARs regarding the delayed records from DOE during 2020. We say this for two reasons, one, we would expect to see notices posted on DEEOIC's webpage regarding this type of issue, and we observed no notice on DEEOIC's webpage during 2020. Second, claimants and ARs generally contact our Office with questions when such information is announced by DEEOIC, and we did not hear of this information being shared with the claimant community. On the other hand, our Office was contacted by an AR who complained regarding the delays in DOE employment verification for multiple claimants after the AR became aware on his/her own that DOE was unable to provide records in a timely manner. The AR questioned whether DEEOIC was taking the DOE delays into consideration when adjudicating these individual's claims, or was denying claims for insufficient employment evidence and then reopening the claims if and when the documents were provided to DEEOIC.

Another AR, writing on behalf of his terminally ill claimant wrote:

The crux of the issue we're having on this and multiple other cases is this: Due to COVID-19 work restrictions the CE's are not getting work history verification requests back in a timely manner. They are however getting Dosimeter Badge Issuance Dates back but they **are not using those dosimeter badges** to verify employment.

³⁹ This DOE office works on behalf of EEOICPA program claimants to ensure that all available worker and facility records and data are provided to DOL, NIOSH and the Advisory Board.

⁴⁰ The August 2020 and December 2020 DOE presentations to the Advisory Board on Radiation and Worker Health can be found at: <https://www.cdc.gov/niosh/ocas/pdfs/abrwh/pres/2020/doe-update-082620-508.pdf> and <https://www.cdc.gov/niosh/ocas/pdfs/abrwh/pres/2020/doe-update-120820-508.pdf>.

The Seattle claims office has specific guidance on using Dosimeter Badge Dates to verify employment for the Nevada Test Site. I have not seen this guidance but I've been told it exists on numerous occasions. The Seattle Claims Office has used Dosimeter Badge Issuance records reliably for years now to verify work history but when the EEOIC Program farmed cases out to the other district offices, this guidance seems to not have been trained or passed along. (Emphasis supplied).

- June 11, 2020 email from AR to Office of the Ombudsman.

Thus, it was unclear if DEEOIC was asking claimants to submit their own evidence to establish their employment and exposures without first informing them that such documentation would have usually been provided by DOE. It was also unclear if all district offices were prepared to adjudicate claims utilizing non-DOE evidence to establish covered employment. And it was troubling for claimants and ARs to discover at a later date that records normally provided by DOE to DEEOIC in the routine course of business had not been available to DEEOIC, and were potentially having a direct impact on their individual claims. It is hoped that as DEEOIC receives the delayed records from DOE regarding cases that have already proceeded through the adjudication process and may have been denied, that DEEOIC will automatically inform claimants when the records become available and grant them an opportunity to file to have their claim reopened.

Likewise, in order to verify claimed employment or establish wage-loss benefits, DEEOIC routinely requests wage earnings records from the Social Security Administration (SSA). *See* Federal (EEOICP) Procedure Manual, Chapter 13.10 (September 14, 2020). Similar to the delays experienced by DOE in producing records for DEEOIC, a claimant complained to us that DEEOIC requested their SSA records in March 2020 and had still not received them in September. The delay was related to the COVID-19 pandemic and directly impacted the claimant's claim for wage-loss benefits in that the adjudication process ceased while the records were delayed. Furthermore, given that there are other ways to establish an individual's wages, the claimant reported that he/she was uncertain what else, if anything, DEEOIC was doing in an effort to adjudicate his/her wage-loss claim.

In Chapter 3 of this report we discussed some of the delays and communication issues claimants and health care providers experienced since the transition of medical billing contractors in April 2020. However, the delays in processing medical bills and out-of-pocket expenses is relevant to this chapter as well. It is not unexpected for there to be hiccups or issues when a transition occurs to a new contractor or new computer system being introduced into a program like the EEOICP. What remains in control of the agency is the notice, communication and guidance provided by the agency to claimants and stakeholders when more than minor problems arise. With respect to the transition from one medical billing contractor to another, the overwhelming majority of claimants, ARs and health care providers who contacted our Office to complain in 2020 stated that they

were not being provided notice of the issues involving the medical billing contractor, nor were they receiving timely communication and guidance from DEEOIC and the contractor regarding how the systemic and individuals issues were going to be resolved. What resulted was not only frustration, but circumstances which may have persuaded some health care providers to no longer treat DEEOIC claimants.⁴¹ And as for claimants who received collection notices for unpaid medical bills, they reported feeling as if they were on their own to figure out how to make sure their bills were paid. That's not to say that some billing issues weren't resolved, but claimants and health care providers found themselves in a position where they were sometimes required to act to protect their own interests as a result of DEEOIC and its contractor not processing their claim in a timely manner.

Other claimants complained about the time it took DEEOIC to develop policies regarding telemedicine appointments. Those who had scheduled a medical appointment prior to the telemedicine authorization by DEEOIC found themselves having to reschedule, and others expressed concerns regarding whether they would be able to keep their scheduled appointments after they were converted to telemedicine appointments. Another claimant complained regarding an appointment to see a specialist that was cancelled due to the pandemic, and then the claimant experienced delays receiving authorization from DEEOIC to travel to the rescheduled appointment. After contacting our Office for assistance, the claimant finally received the authorization to travel, but not until they were already at the destination for their appointment.

A claimant who was informed by our Office of his/her right to request a copy of their file submitted a request to DEEOIC and specifically requested a paper copy of the file. This claimant contacted us again after he/she received a CD instead of a paper copy of the file, and explained that they did not have a computer to open the CD. Claimant complained that this delayed his/her ability to review their claim file information and speak with their doctor regarding obtaining evidence to support their claim.

One AR provided us with a copy of their June 2020 letter of objection to the Recommended Decision which stated, in part, "Claimant requested a copy of [his/her] complete file from Jacksonville in February 2020, but that file has yet to be received, denying the claimant the opportunity to utilize that information in the development of the claim." The AR provided further context by informing us that the claimant was in hospice and unable to assist with gathering any information beyond what was in the claim file.

An issue that DEEOIC has a history of handling with sensitivity and expediency is the adjudication of claims for those who are terminally ill. In the past year or two our Office has received an increasing number of complaints regarding delays in these claims

⁴¹ The issue of claimants having difficulties finding health care providers who will accept payment from DEEOIC was previously discussed in Chapter 3 of this report.

receiving expedited adjudication as a result of the claimant's terminal medical condition. In order for a claim to receive expedited adjudication, "...if medical documents or other information indicate that the claimant is in the end-stage of his/her illness or that death is imminent the [DEEOIC manager] directs case action to occur in an expedited manner and ECS is updated to include the terminal indicator." *See* Federal (EEOICP) Procedure Manual, Chapter 11.8(a) (September 14, 2020). It appears from the complaints we received that records from a hospice physician, which were sufficient in years past to establish a claimant's terminal condition, are no longer sufficient. ARs and claimant's family members have complained that it now seems as if the claimant's treating or hospice physician must use the specific words "imminent" or "end-stage" before DEEOIC will assign a terminal designation to the claim. The ensuing delays and efforts required of family members/ARs to satisfy DEEOIC's requirements by requesting physicians to speculate regarding how much time a claimant has left to live has been described as insensitive.

Finally, an AR complained to us after being unable to determine if the claimant's terminal designation by DEEOIC was being honored by NIOSH. The claimant had terminal brain cancer and the claim had been pending with NIOSH for dose reconstruction for 4 months when we were contacted. Based upon the response from DEEOIC, it did not appear that DEEOIC knew whether NIOSH honored the terminal designation for the claim, writing, "The district office alerted NIOSH that this is a terminal case. I do not know when NIOSH will provide the dose reconstruction report." We were not provided any further information regarding NIOSH's classification of this claim.

Ultimately, such delays heighten anxiety because many people are aware that the death of the claimant prior to receiving monetary compensation: (1) means that the claimant will not enjoy the compensation to which he/she is entitled; and (2) could result in less compensation or no compensation paid to surviving family members. It is our suggestion that DEEOIC provide guidance to claims examiners, hearing representatives, and medical benefits examiners regarding the need for greater sensitivity when requesting medical evidence, as well as clear guidance regarding whether certain words are required to be written by physicians in the medical reports describing a claimant's terminal condition. Additional guidance from DEEOIC will also hopefully generate a consistent understanding between DEEOIC staff and family members/ARs so as to avoid the delays in producing sufficient evidence to satisfy DEEOIC's requirements.

C. Insensitive/Rude Behavior by DEEOIC Staff

Our Office has reported on complaints regarding inappropriate, rude or insensitive behavior by DEEOIC or its contractor's staff in our Annual Reports to Congress each year for the past 10 years. See Office of the Ombudsman Annual Reports to Congress,

2009 – 2019, <https://www.dol.gov/agencies/ombudsman/reports>. These complaints continued in 2020, and we believe that this remains an issue that deserves attention.

Our recommendation to DEEOIC in the 2019 Annual Report to Congress was to continue to evaluate creating a single point of contact to receive complaints of inappropriate customer service. This single point of contact should, at a minimum, acknowledge receipt of complaints and provide the complainant with a response. It was also our opinion that the effectiveness of a single point of contact would be greatly enhanced if the contact was not involved in the adjudication of claims. In 2020, as in past years, when claimants reported rude or insensitive comments by DEEOIC staff to our office, some claimants told us they feared retaliation. Our assurances to claimants that DEEOIC is committed to hearing and addressing their complaints was usually insufficient to ease their concerns. What we repeatedly heard was the fear of reporting a complaint to someone in DEEOIC while the person being complained about sits nearby in the same office, or that their concerns would be immediately shared with the subject of the complaint. A single point of contact could give claimants some confidence that their complaints would be received, acknowledged, responded to, and kept in confidence. Unfortunately, after having made this recommendation for the past few years, it does not appear that DEEOIC has considered implementing this recommendation.

The complaints brought to our attention in 2020 regarding rude or insensitive behavior involved claims examiners, medical benefits examiners, and DEEOIC contractors who were described as being “nasty”, “absolutely awful” and “very rude.” An AR in February contacted us inquiring as to whether telephone calls with claims examiners are recorded after he/she reported being yelled at by a claims examiner during a conversation regarding a decision. When we contacted DEEOIC regarding this complaint we were informed by the claims examiner’s supervisor that the claims examiner denied yelling at the AR. For those who elevated their complaint to a supervisor, the responses they receive are often consistent with the response provided to our Office in this example.

Despite claimants repeatedly describing to our Office, in great detail, the inappropriate behavior of a DEEOIC or contractor staff member, it is challenging for claimants to “prove” how they have been spoken to because DEEOIC does not record telephone calls. And absent the ability for DEEOIC to monitor the telephone interactions of its staff, claimants are unlikely to have sufficient evidence to prove how they were treated. DEEOIC staff record the substance of their conversations with claimants and ARs by writing notes of each call in the ECS database, but it is unlikely any rude or insensitive comments would be self-reported.

Some would argue that claimants should not be required to have proof before DEEOIC would take action regarding these complaints, but without a formal process for individuals to complain to DEEOIC, there is no mechanism by which to gauge DEEOIC’s responsiveness. And absent DEEOIC gathering information and providing

responses to those who file complaints, it is less likely claimants will feel heard or that any rude or insensitive behavior will change.

Chapter 7 – Other Complaints in 2020

A. Industrial Hygienist and Contract Medical Consultant Issues

In certain circumstances, CEs have discretion to forward claims to outside contractor experts such as industrial hygienists (IH) and contract medical consultants (CMC) for their opinions on individual claims. And when these experts provide their reports to DEEOIC, prior to being relied upon in the decision-making process, the IH reports are to be reviewed by the Medical, Health and Science Unit (MHSU)⁴² and the CMC reports are to be reviewed by the CE. *See* Federal (EEOICPA) Procedure Manual, Chapter 15.11(c) and Chapter 16.13(a) (September 14, 2020).

An AR filed a complaint with our Office in 2020 regarding what was characterized as lapses in the supervisory review of the referrals sent from CEs to IHs and CMCs, as well as lapses in the review of the reports produced by the IHs and CMCs. In one instance, the AR noted that the CMC based his/her opinion on the belief that the claimant was a smoker despite no evidence indicating the claimant had ever smoked. The claimant had been issued a Recommended Decision to deny the claim based, in part, on the opinion of the CMC, which included the reference to smoking as the likely cause of the illness. The AR complained that had the CE reviewed the CMC report, the CE should have caught the error regarding the claimant's smoking history. In another instance, when the CE referred a claim to an IH, the CE mingled information from another claimant's case in the Statement of Accepted Facts (SOAF), which contains the factual information the IH relies upon in forming their opinion. Without the MHSU and CE catching the error, the CE accepted the IH report and then sent it to the claimant's treating physician for his/her opinion on causation. The AR caught the errors and upon pointing them out to the CE, efforts were made to correct the errors. This AR questioned the level of review of expert reports when they are returned to the CE and then used during claims adjudication.

A claimant with multiple pulmonary conditions had his/her claim remanded by the FAB to the district office in early 2020 with instructions for the district office to forward the medical and exposure evidence to the claimant's treating physician for an opinion regarding whether the claimant had been diagnosed with asbestosis and COPD. The Remand Order further stated that if the treating physician determined the claimant had asbestosis, the district office was to evaluate the claim under Exhibit 15.4-4 of the Procedure Manual, which outlines the exposure and causations presumptions for certain

⁴² The MHSU conducts and oversees scientific and nursing-related consultative services for DEEOIC staff. This can include industrial hygiene, health physicist, toxicological and nursing related advice and consulting services. Additionally, these staff provide specific medical and scientific research, reporting and advice in the development of policies, regulations and procedures that involve scientific and/or medical issues. *See* Federal (EEOICPA) Procedure Manual, Chapter 2.4(b)(1)(b), Version 4.3 (September 14, 2020).

illnesses, including asbestosis. The treating physician responded to the district office, finding that the claimant had been diagnosed with asbestosis. The AR complained to our Office that instead of considering the asbestosis claim under the causation presumptions outlined in the Procedure Manual, as directed in the Remand Order, the CE unnecessarily sent the claim to a CMC for a causation opinion. The AR also noted that the referral to the CMC further delayed the adjudication of a claim that otherwise met the causation presumption. We cannot comment on the appropriateness of the referral to the CMC in this instance, however, this case does illustrate the challenges claimants and ARs sometimes have with understanding when, and under what circumstances, referrals to outside experts are appropriate. Additionally, claimants and ARs are uncertain as to what recourse, if any, they have when the district office does not appear to follow the instructions in a Remand Order.

Finally, an AR reported to our Office his/her concerns after receiving a copy of the IH report wherein,

...the IH has arbitrarily created his own, subjective standard of required exposure levels, where in reality none exists (in the criteria set forth in the EEOICPA statute). Which begs the next question.

At exactly what level will the amount of exposure satisfy the IH's standard? The SEM does not contain measured amounts of the chemicals, so what authoritative source is the IH referring to? To accept the reasoning of the IH adds an element of evidence to the statute that falls outside its purview.

Part E claims under the EEOICPA do not require proof of exposure levels. And to say it does would be a gross error.

- AR email to Ombudsman, October 2020.

This AR's complaint is consistent with other complaints brought to our attention around the issue of what information and/or resources contractor IHs utilize to determine whether a claimant was exposed to certain toxic substances at a DOE facility, as well as the levels of such exposures. Beyond the information in DEEOIC's Site Exposure Matrices (SEM) database, it is unclear to many claimants and ARs what sources of toxic exposure information, specifically found at DOE facilities, are available to the IHs consideration. And in relying upon those sources of information, claimants also ask how much detail is provided to

IHs regarding the levels of exposure a particular claimant would have had encountered during their employment at a covered facility.

B. Other Complaints

In March 2020, our Office received correspondence from an AR alleging that some Resource Center staff were persuading their clients to change their AR to someone from another business, and that this was occurring when claimants were meeting with the RC staff for their Occupational History interview. According to the AR,

A lot of these clients are older and don't understand the process. They look to the resource center for help instead they are getting questioned and persuaded to change their AR. We have been getting reports of confused clients because they don't understand what is going on. We are asking that you please investigate this.

- Letter from AR to Ombudsman, March 2020.

We informed the AR that while we do not conduct investigations, in the past, when we have brought similar concerns to DEEOIC's attention, DEEOIC stated that their staff and contractors did not steer claimants away from or to any particular AR. The AR responded that they had spoken to someone with DEEOIC and had received the same response. It is oftentimes described as frustrating when ARs or claimants contact our Office with specific allegations or concerns, and it does not appear that DEEOIC has investigated or explored the allegations.

Finally, in our 2019 Annual Report to Congress, we recommended that DEEOIC advise claimants of their right to obtain copies of their claim files, as well as how to request copies of their claim files. However, in 2020, we continued to speak with claimants who were not informed of their right to request copies of documentation from their claim files. In almost all of these cases, the claimants were struggling to provide evidence to DEEOIC regarding the toxic substances they were exposed to while employed at a covered DOE facility. When we informed claimants that it was likely DEEOIC had already requested copies of any/all records from DOE regarding their employment, claimants were confused and frustrated that they were not informed they could request a copy of the DOE records from their claim file in order to assist them in the development of their claim. And for those claimants who had already received a decision to deny their claim, we confirmed for them that this evidence had likely been in their claim file since the early stages of the claims process.

APPENDIX 1 - ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT

ABTSWH	Advisory Board on Toxic Substances and Worker Health
AEC	Atomic Energy Commission
AR	Authorized Representative
AWE	Atomic Weapons Employer
BeLPT	Beryllium Lymphocyte Proliferation Test
CBD	Chronic Beryllium Disease
CE	Claims Examiner
CMC	Contract Medical Consultant (formerly known as District Medical Consultant)
CPWR	Center for Construction Research and Training
DCMWC	Division of Coal Mine Workers' Compensation
DEEOIC	Division of Energy Employees Occupational Illness Compensation
DFEC	Division of Federal Employees' Compensation
DLHWC	Division of Longshore and Harbor Workers' Compensation
DME	Durable Medical Equipment
DOD	Department of Defense
DOE	Department of Energy
DOJ	Department of Justice
DOL	Department of Labor
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
FAB	Final Adjudication Branch
FECA	Federal Employees Compensation Act
FOIA	Freedom of Information Act
FWP	Former Worker Medical Screening Program
HHS	Department of Health and Human Services
HR	Hearing Representative
ICD-10	International Classification of Diseases, 10 th Edition
IH	Industrial Hygienist
IOM	Institute of Medicine of the National Academies
JOTG	Joint Outreach Task Group
MBE	Medical Benefits Examiner
MED	U.S. Army Corps of Engineers Manhattan Engineer District
NDAA	National Defense Authorization Act
NIOSH	National Institute for Occupational Safety and Health
NO	National Office
OWCP	Office of Workers' Compensation Programs
PM	Procedure Manual
PoC	Probability of Causation
RECA	Radiation Exposure Compensation Act
RESEP	Radiation Employees Screening and Education Program
RC	Resource Center
SEC	Special Exposure Cohort
SEM	Site Exposure Matrices
SSA	Social Security Administration
The Act	Energy Employees Occupational Illness Compensation Program Act
The Office	Office of the Ombudsman, U.S. Department of Labor